CALIFORNIA AND WESTERN MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 59 NOVEMBER, 1943 NO. 5

California and Western Medicine

Owned and Published by the
CALIFORNIA MEDICAL ASSOCIATION
Four Fifty Sutter, Room 2004, San Francisco
Phone DOuglas 0062

Address editorial communications to Dr. George H. Kress as per address above. Address business and advertising communications to John Hunton.

EDITOR . . . . . GEORGE H. KRESS

Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number of C. M. A. department, see index below.)

Committee on Publications

F. Burton Jones.....Vallejo 1944
Francis E. Toomey.....San Diego 1945
George W. Walker (Chairman).....Fresno 1946
Secretary and Editor ex officio

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

BUSINESS MANAGER . . . . . JOHN HUNTON
Advertising Representative for Northern California
L. J. FLYNN, 544 Market Street, San Francisco (DOuglas 0577)

Subscription prices, $5 ($6 for foreign countries); single copies, 50 cents.

Volumes begin with the first of January and the first of July. Subscriptions may commence at any time.

Change of Address.—Request for change of address should give both the old and new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

DEPARTMENT INDEX

(Itemized Index of Articles is printed on Front Cover)

EDITORIALS

SURVEY OF CALIFORNIA MEDICAL AND HOSPITALIZATION GROUPS: REPORT AND RECOMMENDATIONS OF LIAISON COMMITTEE OF CALIFORNIA MEDICAL ASSOCIATION COUNCIL

The Mannix Survey.—On February 7, 1943, the Executive Committee of the California Medical Association voted to invite John R. Mannix, of the Michigan Medical Service, to make a survey of California Physicians' Service and the three Blue Cross hospitalization groups operating in California (Hospital Service of California, Oakland; Hospital Service of Southern California, Los Angeles; and Intercoast Hospitalization Insurance Association, Sacramento). For minutes of that meeting, which appeared in CALIFORNIA AND WESTERN MEDICINE for March, see item 12 on page 130. Mr. Mannix secured a leave of absence from his Michigan group, came to California, made the survey, met with the Council, and in due course submitted his detailed report. With certain changes, his report was approved and placed on file (see CALIFORNIA AND WESTERN MEDICINE for July, item 10 on page 75). The revised report by Mr. Mannix—"Voluntary Health Plans in California"—appears in full in this current issue of CALIFORNIA AND WESTERN MEDICINE, on pages 258 to 265. It should be read.

* * *

The Liaison Committee.—A special Liaison Committee was appointed by the Council to bring in a report on the next steps in procedure, the Committee's recommendations appearing in the current number of the OFFICIAL JOURNAL, on page 273. The hope is expressed by the Council that all members of the California Medical Association will take the time not only to read the text of Mr. Mannix' report, but also carefully to scan the recommendations of the Liaison Committee which are to be found in the minutes of the Council meeting held on October 10, 1943 (see item 6 on page 273). It would be in order to have the reports here referred to made the subject of special consideration at the next meetings of each of the California Medical Association's forty component county medical societies. The Liaison Committee (Dr. John Cline, Chairman, San Francisco; Dr. Frank A. MacDonald, Sacramento; and Dr. Edward B. Dewey, Pasadena) will be glad to receive suggestions. Letters can be sent to them direct (their addresses appear on advertising page 2), or may be for-

warded to the Association Secretary, 450 Sutter Building, San Francisco, for transmittal.

At this time it may be stated that the members of the Council of the California Medical Association—who have given many hours of thought to conditions and complications which have arisen in California medical and hospitalization service activities—urge again upon all who have special responsibilities in these matters to keep in mind the importance of the issues at stake. The outlook approach should take into consideration not only the immediate present, but the days yet to come. Let past misunderstandings be relegated to the rear. The question is, how to bring about a unification of endeavors that will more thoroughly promote the fundamental objective of offering to California citizens who belong to the lower income bracket groups, the best medical and hospitalization service available, and at costs within the financial resources of those citizens. If the give-and-take spirit is displayed in broad-minded manner, a happy solution of the major problems should be possible.

MATERNITY-PEDIATRIC PROGRAM OF THE FEDERAL CHILDREN'S BUREAU AND ITS MANDATORY FEE SCHEDULE AND OTHER REGULATIONS

Rules and Regulations of the Federal Children's Bureau Are At Fault.—Because of its deficiencies, the maternity-pediatric program discussion brought into being by the Federal Children's Bureau—through its regulations which, in essence, place in operation in most portions of the United States a mandatory below-cost fee schedule for professional services rendered to wives and infants of enlisted men—will not down. As further California evidence on this point, the attention of readers is directed to the resolutions approved by component county medical societies of the California Medical Association, some of which appeared in the September number on page 178; others, more recently adopted, appearing in this issue on pages 282-284, and 293.

It is as difficult as ever to explain why the lay executives of the Federal Children's Bureau and their medical subordinates should have deemed it proper to inflict upon a profession—whose members, both in the armed forces and in civilian practice, have made for themselves such an exceptional record of generous and wholehearted service to our country and fellows—a compulsory schedule of fee payments and other regulations through a method that may be characterized as a sort of back-door entrance for socialized medicine.

In discussions concerning adequate medical care, it is always a source of wonderment to physicians why certain lay welfare reformers and their governmental co-workers fail to appreciate that some of their supposedly altruistic designs and improvements for "bigger and better medical service" will not do other than result in "lesser and worse medical service" for the very citizens for whom they claim they are working!

* * *

Autocratic Expression of Paternalistic Power.—The maternity-pediatric program of the Federal Children's Bureau is a case in point. Our country is at war. The objective of adequate professional care for the wives and infants of enlisted men is an aim to which all alike give full accord. Nevertheless, it is apparent that members of the medical profession find themselves at a disadvantage in opposing the method of payment for the professional services rendered, as put forth by the Federal Children's Bureau of the United States Department of Labor. Under existing conditions, when its plans are criticized or opposed, it is an easy task for a bureaucracy to apply the smear brush of non-patriotic coöperation. It is all the more regrettable that a small group of persons in a lay governmental bureau—with or without the wholehearted consent of their medical associates and advisors—can be given the power to decide for a group of some 150,000 doctors of medicine the exact amount and procedures in service and payment for stipulated prenatal, confinement, and postpartum care. However, it is a consoling thought to know that it is one thing to give a manifestation of such arbitrary power, and another, to maintain it to the end. In this instance, time will show, especially so, since the program can be maintained only through repeated deficiency bill appropriations by Congress, in the consideration of which the objections of physicians to the Federal Children's Bureau's autocratic rulings may very properly be called to the attention of Congressmen.

* * *

Letter of Council to California Medical Association Members.—The principles at stake in the Federal Children's Bureau plan have such important relationship to the maintenance of proper standards in obstetric and pediatric work that the OFFICIAL JOURNAL of the California Medical Association can follow no other course than to keep the members of the Association acquainted with developments as they arise. For those who are interested, reference should be made to recent maternity and pediatric items (Items XXXI to XXXVII) which appear in this issue on pages 282-284, and 293.

Special attention is called to the letter dated October 22, addressed to the members of the Association (see Item XXXI on page 282), in which the course of action for individual physicians, as interpreted by the California Medical Association Council, is outlined. For double emphasis, the following excerpts are here presented:

The Council of the California Medical Association did not change its action previously taken wherein the decision concerning participation in the Federal Children's Bureau plan was left to individual members of the State Association. In regard thereto, the situation is as follows:

1. The California Medical Association has expressed approval of the objective to provide adequate maternal-pediatric care to the wives and infants of enlisted men;

2. The Council of the California Medical Association has *not* given approval to the regulations of the Federal Children's Bureau whereby the payments *must* be made to the attending physician;

3. Members of the California Medical Association are free agents in this work; each physician to decide for himself under what conditions he is willing to give the indicated professional services.

Since the physician has the privilege of deciding for himself whether he will or will not participate in the plan

outlined by the Federal Children's Bureau, the following additional information is given:

(*a*) A physician is at liberty to sign Part II of the prospective mother's application (which she obtains from a local board of health, the same being a State Board of Health form), but in so doing, the physician obligates himself to give the professional services stipulated for the money consideration also outlined. Further, the physician agrees that he will not accept additional compensation for the said services from the patient or patient's family. Provided, that services rendered prior to the day the prospective mother signed the application, or for services not stipulated in the prenatal, confinement and postpartum agreement, may be charged against the patient. (It is important that the physician read the agreement and inform himself concerning the services he will be called on to render before he signs a prospective mother's application.)

(*b*) Members of the California Medical Association are also free to determine for themselves whether they will accept such patients as private patients, under agreements mutually agreeable between patient and physician; but in such cases the physician must refrain from signing the agreement which the health boards give to prospective mothers who make request therefor.

However, if this latter course of a personal arrangement is followed, it is important to remember that the prospective mother will not be entitled to hospitalization. (Note: However, if the attending physician accepts no remuneration for himself, his patient will be entitled to hospitalization.)

* * *

Resolutions of Five of the Pacific States.—Attention of readers is also called to the resolutions adopted by representatives of the medical societies of Oregon, Washington, Arizona, Idaho, and California, who held a meeting in San Francisco on Tuesday and Wednesday, November 2 and 3, 1943, on call issued by the Committee on Maternal Welfare of the State of Washington. These resolutions appear on page 293.

PUBLIC RELATIONS SURVEY CONCERNING MEDICAL PRACTICE

A Misinformed Public.—At a meeting held on October 10, 1943, the Council of the California Medical Association took action on several matters of great importance to medical practice in California. The minutes appear in this issue and should be scanned or read by every member of the California Medical Association, since the decisions reached may have a direct influence on medical practice in this State at the present time and for the more remote future.

The unsettled conditions that are a part of the global war in which our country is now engaged have led not only to radical changes in industrial, agricultural, and economic relationships, but have also brought to the front a host of social welfare problems. Some of these latter welfare or human betterment proposals have serious implications for medical standards and practice. The proponents of such measures are more than active, not only in putting forth militant educational propaganda, but what is of more serious import, securing legislative enactments designed to lay the foundation for far-reaching plans that would radically change the practice of medicine. Once such a foothold is secured, through either state or federal enabling or other legislation, it is almost certain to follow that the officials concerned with the administration of the activities will seek to enlarge the scope of their jurisdictions and projects. It is well known that many of the plans on matters related to the problems concerned with adequate medical care have been under the sponsorship or supervision of lay persons or bureau chiefs, sometimes with, and at other times, without the advice of physicians who are in active practice.

The proponents of the "new order" put forward their propositions under a banner of idealistic altruism, thus making it doubly difficult for physicians to bring to citizens a proper understanding of the principles at stake. All kinds of smoke screens are used to becloud the issues and, as a result, many voters are persuaded to accept programs with which they would not be in sympathy had they previously been supplied with true information. Because of such propaganda, it is not surprising that the attitude of citizens to the medical profession has undergone a great change in the last ten years or so. If the reaction of coldness or antagonism to organized medicine is permitted to continue, it will not be long before scientific medicine and the quality of medical practice in general will be placed in real jeopardy. Such a result must not be permitted to come to pass. It is not yet too late to bring about a change of view.

* * *

Attention Is Directed to the Survey Now Under Way.—Members of the Association who make a point of keeping in touch with Council proceedings may have noticed Item 9 of the minutes of the meeting of August 22 (page 173 of CALIFORNIA AND WESTERN MEDICINE for August), in which reference was made to the plan submitted by Speaker Askey of Los Angeles, emphasizing the need of a survey that would give to the Association a more accurate picture of California public opinion, in so far as it relates to the medical profession.

In the current issue appears the report of the Special Committee then appointed (Item 5 on page 273). It will be noted that the Council of the Association deemed it to be expedient to authorize the making of a survey, the same to be started at an early date. The services of the well-known firm of Foote, Cone and Belding, successors to the nationally known Lord and Thomas group, have been engaged to do the work. Readers are requested to inform their colleagues of the above action, since it will be possible to carry on the work with better results if physicians generally know about the proposed survey. Doctors will then be in better position to register their approval should they be called on to express to patients or friends an opinion of the investigators operating for the California Institute of Public Opinion, that being the name under which the survey will be carried on. It is hoped to secure an accurate cross section of California public opinion representing all walks in life. With proper support by the physicians of the State, this should be possible. Next steps in procedure will then be in order.

"AGRICULTURAL WORKERS' HEALTH AND MEDICAL ASSOCIATION": ITS MEDICAL ACTIVITIES ENDANGERED

California Medical Association Has Coöperated With the Government.—When, several years ago, the problem of the migratory agricultural workers came to the front in California, the medical care needed by many of the migrants received considerable attention. CALIFORNIA AND WESTERN MEDICINE presented editorial and other comment on the subject. Many readers will remember that when the Council of the California Medical Association was asked for advice by the governmental authorities, the name of Dr. Karl L. Schaupp of San Francisco, present president of the California Medical Association, was submitted for election to the board of directors of the "Agricultural Workers' Health and Medical Association"—a nonprofit corporation under governmental sponsorship, that was created to provide ways and means for adequate medical care of the migratory agricultural workers and their families. It is pleasing to know that the program then established has been successfully administered. Much of the credit for the medical phases is due to the work of Doctor Schaupp, who has given serious thought and time to the enterprise.

* * *

But Now Another Governmental Bureau Steps In.—It would be reasonable to assume that when a governmental agency is doing a much needed and vitally important service in successful manner that its mechanisms of procedure will not be disturbed. But alas and alack, in the present case, another governmental bureau—in an endeavor to make itself bigger, or to show its power, or for obscure reasons of political or other nature that have not yet become fully manifest—has seen fit to break into the picture and secure congressional legislation which, if not amended, may go far in nullifying the good medical care that has been thus far secured for the migrant workers, whose services are much needed in the agricultural districts of the Pacific States.

The bureau to which reference is made is the United States Employment Service. While it may be desirable for that agency to have in its files the names of all migratory workers, and so on, it surely is not necessary for it to espouse legislation that will deny to all migratory workers and their families who, struggling to secure work, merely fail to register through a United States Employment agency. Such a course penalizes the migratory agricultural worker who, in the American way, seeks and obtains work on his own initiative. If regimentation is necessary—and it should not be needed here—why enact it through a system that is obnoxious to the American mode of living? And why should a governmental bureau be so inconsistent and hard-hearted that only those who are willing to secure positions through its offices shall be permitted to have the medical care that has been supplied by the Government in its efforts to keep the migrant workers and their families physically fit? (For Council minute, see Item 15 on page 277.)

Proposed Amendment and Replies from Congressmen.—On other pages in this issue (pages 287-289) appear a copy of the letter which was sent to our California Congressmen in which a proposed amendment to Public Law 45 is indicated, and also the replies of the California representatives in Washington. The items are worthy of perusal. As stated, October 18, in the letter which was sent to Congressmen:

> The present wording of the Act is so restrictive that it excludes from medical care all agricultural workers who do not receive their employment as a result of some activity of some of the Government agencies financed by Public Law 45. This means that our own American agricultural workers who have sufficient initiative and ingenuity to develop employment resources of their own are denied medical assistance.

Component county societies who do not find reply letters from their respective Congressmen in the list elsewhere printed should feel free to again call attention to the proposed amendment. A list of Congressmen with their district numbers is given on page 285. Let us not fail in this. Write to your Congressman and urge enactment of S. 1493 (see page 287).

PROBLEMS IN HOSPITAL NURSE ADMINISTRATION: ALSO A SAN FRANCISCO PROBLEM

Luxury Medicine.—"Luxury Medicine," one of the terms that war conditions have brought to the front, applies alike to certain medical service and nurse care, as given both in hospitals and homes. Under existing conditions, the reasons are understandable why unnecessary demands upon the time and services of physicians and nurses and the facilities of hospitals should not be made, when it is remembered that almost fifty thousand physicians, and more than thirty thousand graduate nurses, have been transferred from civilian into military practice. With such inroads upon physician and nurse personnel in civilian circles—at a time, too, when many communities have taken on increased activities in wartime industries—it should be evident to all that, if remaining physicians and nurses are to keep fit to carry on their work, especially with the extra duties thrust upon them, it will be necessary for all concerned to make sharp adjustments to have available services measure up to the standards laid down in recent years.

* * *

Some Causes of "High Costs of Medical Care."—In many places, the "high costs of medical care" has been partly the joint fault of physicians and patients, since doctors found that time was conserved when patients were given care under institutional conditions; the patients acquiescing to the proposal for such supervision in the belief that recovery, with good results, would also be greatly expedited. The shock came, as a rule, not because the above procedures failed to work out in practice, but because the extra expense involved in professional service rendered in a hospital—(in one sense, an institution providing hotel service only to sick and injured persons)—was over and above what many families were in position to

pay without subjecting themselves to subsequent financial hardships and debt. It is possible, also, that one of the reasons why so many persons have today swung away from the medical profession is due in part not only to the larger amount of specialism that has become the vogue in modern medical care, and its increased expense, but also because, with these newer procedures, there has been lost, and many times, the human understanding, sympathy, and mutual esteem between physician and patient that were so prominent a feature in medical practice up to the last decade or so. Perhaps war conditions will aid in the reëstablishment of the much to be desired former physician-patient relationship.

* * *

Progress in the Nursing Profession.—Medical progress of late years has not been altogether dependent on the medical profession, since its handmaiden, the nursing profession, has been of great aid. The transition from practical to registered nursing, with constant improvement in the education and training provided by accredited schools, has been notable. Therefore, it is not surprising that, in recent years, duty assignments of nurses in many hospitals were changed from twelve to eight-hour shifts. Particularly has this been the case in regard to special nurses.

* * *

Government's War Needs in Nursing Service.—Comes now the war, with 32,000 graduate nurses already in service with the armed forces, and a quota of 32,000 additional nurses to be supplied during the coming year; that campaign being under the sponsorship of the American Red Cross. Nor is this all, for our Government has established the "United States Nurse Cadet Corps," and through the United States Public Health Service and associated groups, seeks to matriculate 62,000 high school graduates during the next twelve months, to receive training in accredited schools of nursing; the costs of tuition and maintenance of the student nurses to be paid by the Government.*

* * *

A San Francisco Hospital Problem.—On other pages of this issue are items telling of certain complications which have arisen in the administration of hospitals located in the San Francisco area. The Stanford Hospital, for example, found it necessary to outline a plan for a readjustment of special nursing. However, as submitted, the changes failed to secure the approval of organized nursing. A modified plan has since been submitted and is being tried out for a period of three months. Here again, medicine and its allied interests are faced with another problem in which the give-and-take elements must come into action if a happy solution is to be found. It is to be hoped that whatever is finally decided upon will work out to the best interests of all concerned, namely, to patients, hospitals, physicians, and nurses. Readers who are interested will find the various items referred to, on page 290.

* For other information, see CALIFORNIA AND WESTERN MEDICINE, September, pages 188-189.

ENTEROHEPATIC CIRCULATION OF ESTROGENS

An interesting contribution to the physiology of sex hormones is contained in proof of an enterohepatic circulation of estrogens recently reported by Cantarow[1] and his associates of Jefferson Medical College, Philadelphia.

Data previously reported by these clinicians[2] led to the belief that considerable quantities of exogenous estrogen are excreted in the bile. To confirm this belief, bile was obtained by duodenal intubation of menopausal women before and after intramuscular injection of 120,000 I. U. diethylstilbestrol. The initial samples were negative. During the first half-hour after injection, however, 440 I. U. were recovered from the bile, increasing to 8,200 I. U. during the fourth half-hour period, and then decreasing to 108 I. U. during the seventh half-hour period. The total biliary excretion during the first three and one-half hour period was 15,558 I. U., or 13 per cent of the intramuscularly injected dose.

In order to confirm the postulated excretion for endogenous estrogens, bile was obtained by the same technique from several women at full-term pregnancy, and three to seven days after delivery. An average of about 800 I. U. estrogen per 100 c.c. was demonstrated in full-term pregnancy bile, contrasted with 250 I. U. in the blood stream. The biliary excretion fell to 240 I. U. by the seventh postpartum day, at which time the blood assay showed only 9 I. U.

Similar tests were made on bile-fistula dogs. After intravenous injection of 4,000 units of chorionic gonadotropin or pregnant mare serum gonadotropin, bile was collected for four consecutive twenty-four-hour periods. These samples showed an average total biliary excretion of 600 I. U. by the end of the fourth day, or approximately 15 per cent of the intravenously injected dose.

In order to determine the subsequent history of this excreted estrogen, 300,000 I. U. (3 mg.) alpha-estradiol in 5 c.c. bile were introduced into an isolated canine jejunal loop. Some forty-five minutes later blood was allowed to flow for a half-hour period from the severed veins, draining this loop. Analysis showed 6,000 I. U. estrogen per 100 c.c. in this drainage blood.

From these and other data, Cantarow concludes that large amounts of both endogenous and exogenous estrogen are excreted in the bile in which it may be present in much higher concentrations than in the peripheral blood or urine. The rapid absorption of estrogen from the isolated intestinal loop points to a very efficient enterohepatic circulation of both exogenous and endogenous estrogen, which may prove to be of practical clinical interest.

W. H. MANWARING,
Stanford University.

REFERENCES

1. Cantarow, A., Rakoff, A. E., Paschkis, K. E., Hansen, L. P., and Walkling, A. A.: Proc. Soc. Exp. Biol. and Med., 52:256 (March), 1943.

2. Cantarow, A., Rakoff, A. E., Paschkis, K. E., and Hansen, L. P.: Proc. Soc. Exp. Biol. and Med., 49:707, 1942.

ORIGINAL ARTICLES

Scientific and General

VOLUNTARY HEALTH PLANS IN CALIFORNIA*

JOHN R. MANNIX
Detroit, Michigan

THE Executive Committee of the California Medical Association at its 180th meeting held in San Francisco on Sunday, February 7, discussed California Physicians' Service and the Hospital Service Plans in California, and voted to make a survey of existing conditions as regards medical and hospital service plans in California. It was voted also that the scope of the survey should be confined to the respective activities of medical and hospital service plans, and how the same may be promoted to the best advantage of the organizations involved and public welfare. The writer was retained to conduct the survey, and this is his report to you.

During the course of the survey, conferences were held with members of the Board of Directors of the California Physicians' Service, Hospital Service of California, Hospital Service of Southern California, and the Inter-Coast Hospitalization Insurance Association. Conferences were also held with officers and members of the Council of the California Medical Association, the Association of California Hospitals, and with a Hospital Service Plan Committee of the latter association. There were also interviews with attorneys for California Medical Association, California Physicians' Service, Association of California Hospitals, and Hospital Service of Southern California. (The attorney for the Inter-Coast Hospitalization Insurance Association was present at a meeting held with the Board of Trustees of that association, and the attorney for Hospital Service of California was present at a general meeting of interested persons held in San Francisco.) There were also interviews with executives of California Physicians' Service and executives of the three hospital service plans, as well as with various practitioners of medicine and hospital executives and trustees throughout the state. During the course of these various contacts, it became evident that progress of voluntary health plans in California was dependent primarily upon proper organization of these plans and coördination of their activities. For this reason the survey was confined principally to consideration of changes in organization which will tend to increase the effectiveness of these organizations, to accelerate their development and to increase their usefulness.

* This survey was made by Mr. John R. Mannix, director of Michigan Hospital Service.

For references to minutes of California Medical Association Council, granting authorization for the survey, see in CALIFORNIA AND WESTERN MEDICINE as follows: March, 1943, Item 12, on page 131; April, 1943, Item 10, on page 239; July, 1943, Item 10, on page 75; September, 1943, Item 8, on page 172.

Purpose of Voluntary Health Plans

Any study of voluntary nonprofit health plans should keep in mind the three primary objectives of these plans, which may be stated as follows:

1. To assure the people adequate medical and hospital care without financial hardship. Voluntary health plans give this assurance by making it possible for the individual or family to budget for the cost of medical and hospital care by making regular payments.

2. To assure the medical profession and hospitals adequate fees for their services and to stabilize the income of both the profession and hospitals. Voluntary plans make this possible by collecting small sums of money from great numbers of people each month, which are redistributed to hospitals and the medical profession in accordance with services rendered by them to such persons. It is obvious that more adequate payments can be made for medical and hospital care if the individual and family have a method whereby they can pay for such care on a periodic basis rather than having to meet the entire cost of such care at the time of illness. This tends also to give the physician and hospital a regular and assured monthly income.

3. To preserve a private practice of medicine and the voluntary hospital system without interference by government, without compulsion, and without taxation. Unless the medical profession and hospitals can make adequate care available through voluntary prepayment health plans, there will be a public demand that government provide health services. As a matter of fact, such a demand on the part of the people already exists. It is, however, not too late for the profession and hospitals to meet the public demand in a voluntary nonprofit way.

Principles of Voluntary Health Plans

The American Hospital Association endorsed principles for the prepayment of hospital service in 1933, and established a list of essentials or principles which should characterize such plans. In 1937 the trustees of the American Hospital Association authorized the approval of hospital service plans meeting these essentials or principles. The House of Delegates of the American Medical Association at its meeting in 1937 adopted principles which were considered necessary to safeguard quality of medical service under hospital plans. The principles adopted by both associations are similar, and it is felt that they apply equally to the medical plans as well as to hospital plans, and are, therefore, summarized here. Any evaluation of health plans should be on the basis of these principles. They include:

1. Emphasis should be placed on the public welfare by such plans. The American Medical Association points out that hospital plans should not be utilized primarily as a means to increase hospital occupancy, nor should they place emphasis on hospital finances.

2. There should be adequate representation of the medical profession, hospitals, and the general

public. The principles provide also that the trustees or board members of the plans should receive no remuneration for service as trustees or board members.

3. There should be nonprofit sponsorship and control. There should be no diversion of funds to individuals or corporations seeking to secure subscribers for profit. No organizations or individuals advancing the initial capital should attempt to influence or direct the management of plans because of their financial support.

4. There should be free choice of hospital and physician. The plan should include all reputable hospitals.

5. The medical profession and hospitals should accept responsibility for service to subscribers. The American Hospital Association states: "The ultimate economic responsibility for service to subscribers enrolled at any given time should be assumed by member hospitals through definite contractual agreements with the hospital service plan." In the case of the medical plan, the medical profession should likewise accept the "ultimate economic responsibility for service."

6. There should be efficient management, adequate accounting and statistical records. There should also be adequate spread of risk, and each plan should serve the largest possible geographic area that legal restrictions and economic conditions permit.

7. There should be equitable payments to the medical profession and hospitals. The American Hospital Association's principles provide that "Payment to hospitals should be based on cost of services provided to the subscribers in hospitals of that community, district or region." Payments to physicians should likewise be in accordance with income which they would receive in the area for similar services.

8. There should be dignified promotion and administration. Employees should be reimbursed by salary as opposed to a commission basis. There should be no commercial or high-pressure salesmanship or exorbitant or misleading advertising to secure subscribers. Such tactics are contrary to medical and hospital ethics and sound public policy.

9. Subscribers' benefits should be based on local professional and hospital practice. The American Hospital Association's principles provide that hospital service provided through a hospital service plan should be determined by the practices of member hospitals of the particular plan. The House of Delegates of the American Medical Association at its meeting in San Francisco in 1938 stated: "If for any reason it is found desirable or necessary to include special medical services such as anesthesia, radiology, pathology or medical services provided by out-patient departments, these services may be included only on the condition that specific cash payments be made by the hospitalization organization directly to subscribers for the cost of the services." (Where medical and hospital service plans are operated in coöperation with each other, as this report recommends should be the case in California, this is easily solved.)

10. There should be no interference with professional relationships. Health plans should not interfere with existing relationships between physicians and hospitals or between physicians and patients.

11. There should be an upper income for subscribers. The principles of the American Medical Association make the foregoing provision. However, it is the present thinking among the majority of people in the medical and hospital fields that while an income limit is desirable in the case of medical service plans, it is not necessary in the case of hospital service plans. The reason for this difference is that it has been traditionally the practice of the medical profession to base their fees on the ability of the patient to pay. This practice, however, has not been followed by hospitals. Different hospital rates are set for given accommodations and generally such accommodations are available to everyone irrespective of their financial resources. In other words, the wealthy man may choose the lowest-priced accommodation and a person with more limited resources may choose the most expensive private room. If, however, a low-cost hospital plan for persons unable to meet the full cost of hospital care is ever developed, then there should be an income limit in such a plan.

12. Health service plans should conform to state statutes and case law.

History and Progress in the Nation

Medical service plans under the sponsorship of medical associations had their origin in 1930, when various county medical societies throughout the states of Washington and Oregon offered medical service on a prepayment basis to people in those states. However, the medical service plan movement did not show much progress until the establishment of California Physicians' Service in 1939. This organization is the first state-wide medical plan under the sponsorship and control of the medical profession. During the four years since the organization of the California Physicians' Service, seven state medical societies have organized similar plans. These are the societies of Massachusetts, New Jersey, Pennsylvania, Delaware, North Carolina, Michigan and Colorado, and the Oregon Medical Association has recently merged the original County Medical Plans formed in that state into a state-wide plan known as Oregon Physicians' Service, so that there are nine state-wide medical plans at the present time. In addition to state-wide medical plans, plans under sponsorship of local medical associations are now in operation in New York State, Texas and Washington, and the medical professions in at least five other states are giving serious consideration to the development of medical plans. These states include West Virginia, Georgia, Ohio, Wisconsin, and Utah. Exact figures on medical service plan enrollment are not available. However, as of March 1, 1943, California Physicians' Service had enrolled approximately 88,000

subscribers; Michigan Medical Service had enrolled approximately 440,000 subscribers. Enrollment in Washington and Oregon exceeds 200,000 subscribers, and the total enrollment in the twelve states having medical plans is over 800,000 subscribers.

Throughout the nineteenth century and during the early part of the twentieth century, there were many hospital service plans operated by individual hospitals, but it was not until 1932 that a plan was organized offering free choice of hospital. This plan was started at Sacramento, California, in July, 1932. The formation of this plan may well be said to be the start of the present development of voluntary nonprofit hospital plans offering free choice of hospital. During 1933 and 1934, other free choice hospital plans were organized at Newark, New Jersey; St. Paul, Minnesota; Durham, North Carolina; New Orleans, Louisiana; Washington, D. C.; and Cleveland, Ohio. By 1935 twelve hospital service plans had enrolled 97,000 subscribers. By January, 1940, sixty plans had enrolled 4,500,000 subscribers. On April 1, 1943, seventy-seven plans had enrolled over 11,000,000 subscribers. These plans are operating in thirty-five states, the District of Columbia, and three provinces in Canada. These seventy-seven plans bear the Blue Cross stamp of approval of the American Hospital Association, having met the approval standards outlined previously in this report. The thirty-five states and the District of Columbia where Blue Cross Plans are operating contain approximately 90 per cent of the population of the United States and the three provinces contain approximately 40 per cent of the population of the Dominion of Canada. Of the thirteen states without Blue Cross Plans, four already have special enabling acts, and efforts are being made by the Hospital Service Plan Commission of the American Hospital Association to establish plans in all thirteen states at a very early date.

There has been a truly spectacular development of nonprofit health plans during the past eleven years. There were many enthusiastic persons who attended the first conferences on group health care during 1933 and 1934, but few of them visualized the coming growth and future magnitude of this movement. Despite the development which has taken place, there are many friends of this movement who honestly believe, and many opponents who contend, that these plans have reached their full development and cannot be expected to reach a much larger portion of the people. However, it is our prediction that with the support of the medical and allied professions, and with the support of hospital trustees and executives, all the people of this country will be relieved of the financial burden of health care within a reasonably few years through medical plans and companion Blue Cross hospital plans.

Progress of California Physicians' Service

California has the honor of being a pioneer in the health service plan movement. As previously stated, the first free choice hospital service plan was organized at Sacramento in 1932, and the first state-wide medical plan was organized in California in 1939. Much of the credit for the present nationwide development of health plans must be given to California. However, while California has been a pioneer in both the hospital and medical service plan fields, nevertheless, many other areas of the country have enjoyed greater success.

Consider first the growth of California Physicians' Service. After four years of operation this plan has enrolled 88,000 subscribers, or approximately 1.2 per cent of the population, whereas Michigan Medical Service, which was started a year later, has enrolled 440,000 subscribers, or 8 per cent of its population. At the present rate of growth, it would take over 300 years to enroll all Californians in California Physicians' Service.

There appear to be several reasons for slow progress in California. These include:

1. The feeling upon the part of some physicians that California Physicians' Service was established for the sole purpose of forestalling state medicine. While this may well be one of the results, physicians must appreciate that such plans are necessary to assure the public of adequate medical care without financial hardship, and at the same time to assure the physician a fair fee for all his services.

2. Failure on the part of the plan to capitalize on early public interest in the program. This enabled commercial insurance companies, group clinics, and industrial plans to prosper and enjoy rapid growth while California Physicians' Service was being organized and starting operation.

3. Tendency to place emphasis on development of medical service through government agencies, namely, through Farm Security Administration and Federal Housing Authority rather than through regular industrial and business groups. Over 50 per cent of the present enrollment of California Physicians' Service covers persons who are Farm Security Administration clients or persons who occupy Federal Housing Authority homes.

4. Tendency to offer an ideal medical service contract providing complete medical service rather than offering a contract for partial or limited medical care, which could be offered at a relatively low rate, and which probably would be of interest to much greater numbers of persons at the present time.

It is believed that a great part of the success of voluntary health plans is due to the fact that eleven years ago, hospital service was offered to the employed individual only for rates as low as $.02 a day, or $.60 a month. It was because of the smallness of this charge that hundreds of thousands of people availed themselves of this service. After four or five years' experience with such a contract, there developed a great demand for hospital service for the entire family. This was then offered at rates as low as $.05 a day or $1.50 a month. This time millions of persons throughout the country availed themselves of this protection. In 1939 and 1940 California Physicians' Service, Michigan Medical Service, and Western New York Medical Service

offered hospital and medical care to the individual at rates of approximately $2.50 per month. The Michigan and Western New York plans also offered hospital and medical service to the entire family at rates of approximately $6 per month. In none of these instances were the medical plans successful, and it is believed that the reason for the lack of success was the fact that individuals who were paying $.60 to $.80 a month for hospital service were not yet ready to pay approximately $2.50 a month for complete medical care, and families who had been paying approximately $2 a month for hospital service were not yet ready to pay approximately $6 a month for complete medical care. In light of these experiences, it appears wise to offer only partial medical protection at this time, and the greatest demand appears to be for contracts offering hospital and surgical service.

5. Another factor affecting development in California is the complicated rate structure. Subscriber rates have been changed from time to time, and different rates are quoted for large groups and small groups, for males and females, for families with one child, and families with a greater number of children. This complicated rate structure makes it very difficult for representatives in presenting the plan to employers and prospective subscribers. The rate structure can be greatly simplified and still result in the same income per person protected. When this is done, a much more effective presentation of the plan can be made.

6. Another factor retarding progress is the difference in benefits and difference in restrictions and limitations between hospital service plan contracts and the medical contracts. It is believed that the surgical service contract should include obstetrical care not only in the case of ectopic pregnancies and cesarean operations, but also in case of normal deliveries. In other respects, benefits, limitations and enrollment regulations of the medical plan and the hospital plan should be similar.

7. One of the principal obstacles to the development of California Physicians' Service has been the fact that the unit value of physicians' services has been such a low point. This has resulted in lack of support on the part of many physicians, which in turn affects the public confidence in the plan and prevents progress. Every effort should be made to increase the value of the unit. It is believed that this can best be done by placing emphasis on a surgical service contract, and offering a medical service contract with the two-visit deductible feature only in those instances where there is insistence upon this type of contract. It is further believed that the surgical service contract can be offered at a rate that will permit payment to the doctor of a full-fee schedule or full unit value.

8. California Physicians' Service has not had the full and wholehearted support of a substantial majority of the physicians in the state and in several counties has had little or no support. In a sense the plan cannot be considered a truly state-wide plan. The plan must have the support of the great majority of the physicians, if not all physicians, before real success can be expected. Physicians should accept the responsibility to render service to subscribers under the plan, and it is believed that the agreement with physicians should provide that they will furnish service for a twelve-month period, and that cancellation of their membership is only effective under twelve months' written notice. The average person cannot be expected to enroll in the plan unless there is some assurance that participating physicians will continue to render service for a reasonable period of time.

9. Another factor which has hindered the development of the medical plan has been the lack of complete coöperation with the hospital plans, and coördination of these plans with the medical plan. At the present time there are really four hospital plans in the state, one being offered by California Physicians' Service, and the others being offered by the Hospital Service of California, Hospital Service of Southern California, and Inter-Coast Hospitalization Insurance Association. There are three medical plans, one offered by California Physicians' Service, one offered by Hospital Service of California, and one offered by Inter-Coast Hospitalization Insurance Association. The offering of four hospital plans and three medical plans in the state is ample evidence to the public of the lack of coöperation within the medical group and within the hospital group, as well as between the medical profession and hospitals. Until this situation is corrected, much progress cannot be expected. There must be coördination of medical and hospital plans as regards rates, benefits, contract limitations, enrollment regulations, office procedure, as well as general policy.

Progress of California Hospital Plans

There are three hospital service corporations in California. The Sacramento Plan has been operating since 1932, the Oakland Plan since 1937, and the Los Angeles Plan since 1938. As of January 1, 1943, these three plans had enrolled 127,812 people. This is 1.8 per cent of the population. At the present rate of growth, it will take 300 years to enroll all of the people in California. It is interesting to compare the percentage of enrollment in California with the percentage of enrollment in the ten most populous states. This enrollment follows:

	Per Cent
New York	15.7
Pennsylvania	11.4
Illinois	8.0
Ohio	20.9
California	1.8
Texas	1.0
Michigan	16.1
Massachusetts	10.6
New Jersey	10.0
Missouri	9.9

It will be noted that eight of the ten most populous states in the Union have enrolled 8 or more per cent of their population in approved Blue Cross Plans. This again compares with California's 1.8 per cent. Only Texas, which has a relatively new plan, shows a lower enrollment.

It is also interesting to compare California's enrollment of 1.8 per cent with that in states having state-wide plans. Enrollment in some of the state-wide plans is as follows:

	Per Cent
Alabama	3.2
Maine	6.3
Maryland	8.8
Massachusetts	10.6
Michigan	16.1
Minnesota	18.5
New Jersey	10.0
Rhode Island	16.6
Colorado	15.1
Delaware	22.5
North Dakota	4.3

The above figures would seem to indicate that much more rapid acceptance of prepayment hospital service might be expected if there were a single state-wide plan in California.

Until 1932 when the Sacramento Plan was organized, all hospital service plans were operated by individual hospitals. From 1932 until 1938 we witnessed the development of community-wide hospital service plans. Since 1938 the tendency has been to develop hospital service plans on a state-wide basis. There are now plans in thirty-five states, the District of Columbia, and three provinces of Canada. Twenty plans are state-wide, one serves the District of Columbia, and three plans are province-wide. On the other hand, fifteen states, of which California is one, have a total of fifty-two plans, operated on a community or local area basis. Some of the early community plans are now state-wide; this is true in the case of the Newark plan, which now serves the State of New Jersey, and the St. Paul plan, which serves the State of Minnesota. State-wide plans are being considered in New York, Ohio, Illinois, Kentucky, North Carolina, and Louisiana. At the present time these particular states have from two to nine plans each. There are a number of advantages to the development of hospital (as well as medical) service plans on a state-wide basis. These advantages are:

1. From the standpoint of the subscriber, there is a much greater choice of hospital, and therefore the plan is more appealing to him. There is still a great deal of travel even during the war period, and the subscriber realizes the advantage of having the privilege to go to any hospital in the entire state in case of emergency, securing care on a service basis, rather than having service limited to hospitals in his community.

2. From the standpoint of the employer, particularly the state-wide employer, there is the advantage that he has only one plant rather than several with which to deal. This simplifies his problem in offering hospital care to his employees, not only from the standpoint of the presentation of the plan, but also from the standpoint of office details in connection with pay-roll deduction and other matters.

3. From the standpoint of the hospital, there is but one plan to deal with rather than several. This tends to simplify the hospital problem, particularly from an admitting office and accounting standpoint. At the present time there are no two hospital service plans in the country with the same admission forms and regulations, or the same billing forms or regulations. This situation greatly adds to the clerical problem of the hospital.

4. From the standpoint of the hospital service plan, there are several advantages in a state-wide plan. Inasmuch as free choice of hospitals throughout the state is offered, the contract is much more attractive and individuals in a group are more likely to be interested in the service.

State-wide or national employers are much more likely to coöperate with a single state-wide plan than they are with a group of local plans. This also increases enrollment.

Perhaps the most important advantage is that in a state-wide plan there is a much greater spread of risk. This leads to greater financial soundness, inasmuch as state-wide plans would not be affected by local fluctuations in the incidence of hospital care to the same degree that local plans would be affected by such fluctuations.

There are a number of conditions hindering state-wide development. These conditions include:

1. The matter of local pride. The trustees and executives of local hospital plans as well as the trustees and executives of local hospitals are generally very proud of their accomplishments. They hesitate to merge their interest with those of adjoining communities. However, it is believed that all groups can render a much more valuable public service by extending their interest to a state-wide basis rather than confining it to a local community.

2. There is also the question of relative reserves built up by various community plans. Plans having built up large reserves hesitate to merge with those having smaller reserves. However, it is believed that this problem is easily solved by first determining the minimum amount of reserve on a subscriber basis held by each plan, and having each plan contribute the amount of this minimum to a common reserve fund in the new state-wide corporation. Any excess reserve over and above this minimum held by a particular plan could be held by the new corporation for the special protection of the hospitals and subscribers in the area where their reserve was created for a period of three to five years, after which time any balance of the special reserve which remained could be transferred to the common reserve fund.

3. Another difficulty delaying forming of state-wide plans is the fact that hospital costs and charges differ throughout the state. However, this problem has been solved satisfactorily in the twenty-four states or provinces having state-wide or province-wide plans, and can be solved in California by fair consideration of all the factors involved.

4. A fourth situation hindering state-wide development is the feeling that "this state is different." In California, for instance, there is a feeling that because of certain differences between Northern and Southern California, and the size of the state from both an area and population basis, it might be advisable to have a Northern California Plan and a Southern California Plan. However,

the territorial differences that exist in California are no different from those which exist in states like Massachusetts, New Jersey, Minnesota, Michigan, and Colorado, which have successful state-wide plans. State-wide plans have been successful in states like Michigan, Massachusetts, New Jersey, whose total population is close to that of California. They have been successful in states like Minnesota, Michigan, and Colorado, which cover very large areas.

There are many important reasons for state-wide development of hospital service plans, and no valid objections. It is felt that the development of a single state-wide hospital service plan in California is of primary importance in the future of the hospital service plan movement, not only in this state, but throughout the nation.

Federal Government Proposals

Since the development of compulsory health insurance in Germany in 1880, there have been numerous legislative attempts to introduce compulsory health insurance in various states of the Union, as well as on a national basis. These attempts are largely the result of public pressure which results from the fact that relatively few people can meet the cost of medical and hospital care at the time of illness, and inasmuch as this problem has not been successfully met on a large scale by the medical profession and voluntary hospitals we get pressure on government. While this pressure has not been well organized, there can be little doubt that there is great public interest in such proposals. This was evidenced late in 1942 when a poll by *Fortune Magazine* showed that 74 per cent of the population of the United States was in favor of some form of government health insurance. In January, 1942, President Roosevelt, in his budget message to Congress, recommended that the Social Security Law be amended to provide for hospitalization benefits. Legislation covering the President's recommendation was later introduced in Congress. This legislation was known as the Elliott Bill. This bill was not successful, but similar legislation, known as the Greene Bill, has been introduced in the 1943 session of Congress. No reasonable person objects to the Federal Government entering any necessary activity where private enterprise and individual initiative have failed, but we do not believe that any person who feels that individual initiative and private enterprise are important to the American way of life will agree that the Federal Government should enter into any activity where great progress is being made through the conscientious efforts of private agencies. We feel, therefore, that it is important that the medical profession and voluntary hospitals develop successful voluntary health plans on a nonprofit basis. These plans must be so developed that we will reach millions of Americans through them. It is not enough that 800,000 persons now have voluntary medical plans, or that 11,000,000 persons are protected by voluntary hospital plans. We must think in terms of medical and hospital coverage through voluntary nonprofit agencies for at least 50,000,000 persons within the next decade if the American public is going to approve voluntary plans, and if the demand for compulsory health insurance is to be dropped.

Voluntary hospital service plans known as contributory schemes have been very successful in England, and it is interesting that Sir William Beveridge, in his Report on Social Insurance and Allied Services in England, in which he proposed various forms of security "from the cradle to the grave," including national medical service, makes special exception in the case of hospital contributory schemes. He states: "The growth of hospital contributory schemes in the years just before this war has been remarkable. They are stated to cover more than 10,000,000 wage-earners, and they produce more than 6,500,000 pounds a year for the voluntary hospitals; the cost of collecting this money is put at about 6 per cent; in London and some other parts of the country, contribution to a hospital saving association qualifies the contributor for free treatment either in a voluntary hospital or in a public hospital as may best suit his case. . . . Should a payment for this purpose be included in the compulsory insurance contribution, and be passed on as a grant from the social insurance fund to the health departments toward the maintenance of the institutions? The answer to this financial question, like the answer to the other similar question, as to domiciliary treatment, involves problems of organization as well as finance. If payment for institutional treatment is included in the compulsory insurance contribution, there will be little or nothing left for which people can be asked to contribute voluntarily, and an important financial resource of the voluntary hospitals will come to an end. It will then be for the health departments to use the grant that they will receive from the social insurance fund in whatever way best fits their hospital policy. If it is not included, people of limited means will have the choice, as at present, of contributing voluntarily beforehand, or paying at the time of treatment, as best suits their means."

This statement would indicate that while Sir William Beveridge believes that Government protection from the "cradle to the grave" should be provided for every individual, on the other hand he believes that the hospital contributory schemes which are one of the most successful forms of protection now available to the English people, should not be disturbed. It is reasonable to believe that if the medical profession and the voluntary hospitals of the United States make voluntary health plans available to the great mass of American people on a nonprofit basis, we will have little to fear in the way of compulsory health insurance in this country.

Recommendations

A study of the history and development and present status of medical and hospital service plans in California has resulted in a number of conclusions which are set forth in the following recommendations:

1. There should be developed a new nonprofit corporation for the purpose of operating a state-

wide hospital service plan. This corporation should be organized under the nonprofit hospital service plan section of the Insurance Code of California. It should be developed in accordance with the approved standards adopted by the American Hospital Association and the American Medical Association. It should, upon approval of the hospitals of the state and the three present hospital service plans, takeover the operation of the three plans, as well as their assets and liabilities; the reserves of the three plans to be handled in the manner described elsewhere in this report.

2. The activities of the new state-wide hospital plan should be coördinated with those of California Physicians' Service. There is need for coördination at three levels: first, the trustee level; second, executive committee level; and third, executive level. It is recommended that coördination at the trustee level be obtained by election to the medical plan board by participating hospitals in the state-wide plan of a number of trustees to be later agreed upon, and, further, that there be elected by participating physicians, by their duly constituted representatives in California Physicians' Service, an equivalent number of physicians in active practice to serve on the hospital plan board. It is believed that the interlocking of the board of California Physicians' Service and the Hospital Plan board will prevent misunderstandings and conflicting actions which might occur if individual actions on similar matters taken by two entirely different boards, meeting at different times and at different places and acting on similar matters.

It is proposed that there be an executive committee made up of an equal number of representatives from California Physicians' Service who shall be physicians in active practice and the Hospital Service Plan board; this executive committee to be responsible for the operation of both corporations.

It is further proposed that the executive committee employ an executive who will be in charge of the actual day-to-day operation of the affairs of both corporations. This executive would be responsible to the executive committee, and have charge of all employees necessary in operating the medical and hospital plan. This executive should be an individual who would have the confidence of the medical profession and hospital executives, who has an understanding and sympathetic interest in private practice of medicine and the voluntary hospital system. He should have had experience in the medical and hospital service plan field, or in allied fields which would qualify him for this position. He should have proved executive ability as well as the ability to contact the large employers of the state and to receive a sympathetic audience from them.

3. It is also recommended that there be a merger of the operating organizations of California Physicians' Service, Hospital Service of California, Hospital Service of Southern California, and the Inter-Coast Hospitalization Insurance Association. There should be a complete merger of all such activities as promotion, acquisition, enrollment, contract issuance, record keeping, billing and collection, and payment for service. There should be established a department of physician relations, the duty of which should be to keep the medical profession informed at all times of the progress of the organization and other matters of concern to the physician. There should also be developed a corresponding department of hospital relations, the duty of which shall be to keep hospital trustees and executives informed at all times of the progress of the Association and other matters affecting them.

4. It is proposed that there be developed by California Physicians' Service a separate subscribers' contract covering x-ray, medical anesthesia and pathological laboratory services. Income accruing from this contract would go to California Physicians' Service, which would, in turn, make all payments for these services. This would permit the offering to the public of a contract for hospital service, as well as an additional contract for certain medical services.

5. It is proposed that there should be a detailed actuarial study of the medical service plan and the limited surgical contract with the thought of offering services as comprehensive as possible at a subscribers' rate which will be attractive and which at the same time will assure the profession an adequate fee for its services. It appears wise to offer only partial medical protection at this time, and the greatest demand appears to be for a contract offering surgical service only. Such a contract is now being offered in California, Michigan and the western New York plans, which have had more experience than any other groups in writing medical services on a prepayment basis. Similar contracts are being offered also by all of the other medical service plans in the East. It is believed that only as the public has experience with the surgical service contract which can be offered at a relatively low rate, will they become interested in availing themselves in great numbers of more complete medical care at the higher rate which must be charged. As stated elsewhere, it is believed that a surgical service contract can be offered at a rate which will be acceptable to hundreds of thousands of people, and which rate, at the same time, will be sufficient to make payment to the physicians of an adequate and fair fee.

6. It is further recommended that the state-wide hospital plan adopt a comprehensive contract without restrictions and limitations (as recommended by the Hospital Service Plan Commission of the American Hospital Association, keeping in mind recommendation No. 4, above). Actuarial studies should be made to determine the subscribers' rate which will be necessary to make payment to hospitals at a fair and reasonable rate for their services. In this connection, it is recommended that a committee representing the hospitals of the state be asked to study hospital costs and charges for the purpose of developing a rate structure which will be fair to all institutions.

7. It is recommended that California Physicians' Service and the new Hospital Plan be developed in such a fashion so as to be in a position to serve the

adjoining states of Arizona and Nevada. Arizona has a population of approximately 500,000 persons, and Nevada a population of 110,000 persons. These states are hardly large enough to support successful medical and hospital plans. If the people of these states are to secure medical and hospital service on a voluntary prepayment basis, they probably will have to be served by the medical and hospital plans which also serve the State of California. The Inter-Coast Hospitalization Insurance Association is now serving Nevada, but it is felt that Arizona should also be served by the hospital and medical plans in this area.

8. It is recommended that every member of the medical profession in California (as well as Arizona and Nevada) should enter into an agreement to render service under the California Physicians' Service plan for a period of one year. It is likewise recommended that all general hospitals of these states registered by the American Medical Association enter into a contract to furnish hospital service for a one-year period. These contracts should be clear as regards the ultimate economic responsibility of the medical profession on one hand and the hospitals on the other to render medical and hospital service as provided for in the subscribers' contract. Without the acceptance of this responsibility upon the part of the medical profession and hospitals, and without the complete and enthusiastic support of both groups, nonprofit health plans can never be successful.

9. It is recommended that the public be represented in the operation of the medical and hospital plans. It is proposed that this be done in two ways: first, by the appointment of three advisory committees of five members, each representing the business fraternity, the labor group, and the agricultural group. Matters of interest to them should be discussed with them from time to time, and their advice should be presented to the Board of Trustees of both the plans for consideration and action. It is further proposed that there be established a sponsoring committee in each area of the state where branch offices are established. These sponsoring committees should consist of from six to as many as twenty-five of the citizens of the area representing the various groups of the area. Problems of interest to them should be presented to these sponsoring committees from time to time, and their advice should be referred to the two Boards for their consideration and action. It is recommended that there be at least quarterly meetings of the advisory committees, and at least semi-annual meetings of the sponsoring committees.

10. It is recommended that there be employed a public education director. This individual should have had experience in newspaper or related fields. It should be his duty to develop direct mail, newspaper and magazine releases, and other material which would keep the employers and public throughout the state informed regarding the medical and hospital plans. The four plans of the state have been weak in the matter of proper public education and public relations. Medical and hospital plans cannot be successful unless the public understands what they are attempting to accomplish and what they have to offer.

* * *

It is suggested that if this report and its recommendations are acceptable to the Council that copies be forwarded to the proper officials of the California Physicians' Service and the three Hospital Plans, and it is further suggested that, in order to carry out the recommendations of this report, the California Medical Association and the Association of California Hospitals both appoint committees of not more than five members, whose duty it would be to take such steps as may be necessary to put these recommendations in effect. The California Medical Association committee would deal with matters affecting medical practice and California Physicians' Service. The Association of California Hospitals committee would deal with matters affecting hospital service and the three hospital plans. In matters concerning both medical and hospital practice, or the medical and hospital plans, the two committees would serve as a joint committee.

California is the fourth largest state in the Union in population, and unquestionably one of the most important. The future of the private practice of medicine and the voluntary hospital system may well depend on the success or failure of voluntary health plans in this state. California is in a position to make an outstanding contribution to the voluntary health plan movement, and to the preservation of private practice of medicine and the voluntary hospital system.

234 State Street.

Respectfully submitted,

JOHN R. MANNIX,
Director, Michigan Hospital Service.

TREATMENT OF BIRTHMARKS*

WILBUR BAILEY, M. D.
AND
WILLIAM KISKADDEN, M. D.
Los Angeles

MOST vascular birthmarks can be decreased markedly in size or even eradicated by a number of different methods. Since many of these disfiguring lesions occur in conspicuous places, the method of treatment selected should be one which substitutes for the hemangioma either normal skin or a scar which resembles it as closely as possible. Most of the unsatisfactory results of treatment can be attributed to the selection of the therapeutic agent without regard to its appropriateness for the character or type of hemangioma which is to be treated.

INCIDENCE

Vascular birthmarks are relatively common. Although some authorities believe that as much as

* Read before the Section on Pediatrics, at the Seventy-first Annual Session of the California Medical Association, Del Monte, May 3-6, 1942.

one-third of all infants show such marks at birth, it is our impression that only one-tenth or one-twelfth of all infants show such lesions.

The location is of even more importance. Watson and McCarthy[1] call attention to the fact that, although the head and neck make up less than one-seventh of the body surface, more than half in their large series of cases were found to be in these conspicuous locations. Peculiar, also, is the fact to which most authors agree, that the males outnumber the females in ratio of two to one, or even three to one. The former ratio is in accord with our experience of 92 cases treated in the last six years of private practice.

CLASSIFICATION

There are three types of vascular birthmarks, all of which may be present in the same tumor. Since the method of treatment which is selected depends not only on the size, shape, location, and growth characteristics of the tumor, but also upon the histological structure, classification is of major importance.

1. The "capillary hemangioma," or "port-wine stain," sometimes referred to as a hemangioma simplex, consists of a number of increased venules and capillaries in the deeper layers of the skin over which the epidermis is thin and velvety. All pediatricians are familiar with the simplest form of hemangioma simplex, which takes the shape of irregular patches of redness in the region of the eyelids, nose, forehead or in the nuchal region in the newborn. These red blotches almost invariably disappear six or eight months after birth. They are for this reason unique, for, although spontaneous regression may occasionally occur in other forms of hemangoima, it is rare.

In the more complex form, the capillary hemangioma is constituted by the familiar fiery red or purplish port-wine stain usually found on the head or neck, which is frequently in the distribution of the trigeminal nerve. The fact that the vessels lining these capillary hemangiomata have a well-differentiated lining of the adult variety, is of considerable importance from a therapeutic standpoint, for it explains the resistance to radium and other forms of therapy.

Unsatisfactory results in the treatment of capillary hemangiomata may be expected from radium or x-ray, for the advanced differentiation of the blood vessel endothelium in these lesions in adults is unlike the other forms of hemangiomata in which less endothelial differentiation is present. Unusually heavy doses of x-ray or radium are required to effect destruction of the well-differentiated lining in these blood vessels. Such heavy dosage, or even prolonged treatment with carbon dioxide snow, may cause the port-wine stain to become irregularly faded or pigmented. The final result is usually a geographical appearance which is considerably more disfiguring than the original lesion. With x-ray or radium the same danger is present as in the use of these agents for removing superfluous hair. To be effective, the dose must be sufficiently large to produce skin atrophy. As a result, the sebaceous glands are destroyed, the skin becomes dry, and even covering cosmetics will no longer adhere satisfactorily to it.

2. The second classification of hemangioma is the type generally known as the "strawberry mark," sometimes called "hypertrophic endothelial hemangioma." This name is suitable, because the underlying pathological histology is described by it.

Masses of endothelial cells are found displacing the skin and subcutaneous tissues. The prolifie growth of these cells is so great that many of the blood-vessel walls are compressed as the tumor grows, and appear only as fissures in the histological section.

This lesion, with its bright red, irregular top elevated above the surface of the normal skin, is clinically the most familiar of the three types. Frequently growth is rapid, and in two cases in our series in which twins were involved, the rapidity of growth appeared to be almost malignant in nature. Typical metastases have been reported in the literature.

The masses of endothelial cells which are shown histologically are of therapeutic and prognostic importance, for such undifferentiated tumors would be expected to be highly radiosensitive, and, as a matter of fact, they nearly always are.

3. "Cavernous hemangioma" constitutes the third classification. These deep tumors may be covered by entirely normal skin, but can usually be distingusihed through the overlying skin as a swelling which is purplish in color. Histologically, the vessels have the same juvenile type of endothelium which is found in the "strawberry marks," and are, accordingly, more sensitive to radiation and other forms of therapy than are the adult types of endothelium which appear in the port-wine stains.

TREATMENT

The treatment depends to a great extent upon the classification of the tumor. With capillary hemangiomata or port-wine stains, excision is usually the therapy of choice. Ultraviolet radiation is occasionally successful. Cosmetic covering pastes are often very satisfactory in women. The other main classifications consisting of the "strawberry marks" and "cavernous" types of hemangiomata can be treated in a variety of ways. Surgical incision can, of course, be used for any type of hemangioma. Frequently, however, these lesions are on the face, or are so large or are located so close to important vessels or nerves (especially the seventh), that excision is not practicable. After other methods have been used, surgery may be appropriate for excision of scar tissue in some cases.

Destructive methods are many in number, and are aimed chiefly at sclerosing the lining of the vessels. For this purpose fulguration with cautery, insertion of hot platinum needles, pressure to produce luceration, scarification, or even vaccination have been used. Injection with a great number of different substances, electrocoagulation, freezing with carbon dioxide snow, and x-rays and radium, are all in use at the present time.

Considering the number of methods which are available, it is important that the one be selected that will yield the best cosmetic end result. Most poor results are ascribable to two causes:

1. Watchful waiting on the part of the physician and family in the hope that the lesion will regress. Such regression occasionally occurs, but much valuable time is often lost while the lesion doubles or trebles its invasive growth during the futile period of waiting.

2. The wrong therapeutic agent is selected. Such wrong selections are usually made, because due concern is not given to the depth, extent, and particular type of lesion. Carbon dioxide snow or the beta rays of radium, for instance, are not suitable, and are even dangerous in the treatment of deep hemangiomata, yet they are all too frequently used in such cases.

The more common methods will be reviewed with particular attention to their applicability:

1. Surgery.—We believe the viewpoint that surgery should be employed in all cases is too radical. Selected cases, however, often lend themselves to easy surgical excision. Superficial lesions about the eyelids can usually be removed most easily by excision. Skin grafts can be substituted for large birthmarks, but the decision must be made as to whether the patchy appearance of a graft is more to be desired than the lesion itself, or the results obtained following the use of radium.

If the lesion is elevated, it is our belief that radon seeds should be implanted first, or that radium packs should be used as described later. If necessary the final skin result can be further improved by grafting.

2. Electrocoagulation.—Electrocoagulation has been recommended by Figi[2] for use in cavernous hemangiomata in adults as well as infants. The chief difficulty with this method is in gauging the intensity and extent of the coagulating process. Should this amount of cooking be too great, sloughs are likely to produce unsatisfactory scars.

3. Sclerosing Solutions.—The use of sclerosing solutions dates from almost 100 years ago when Pravez,[3] prior to 1845, injected ferric chloride of coagulation of blood in aneurysms and hemangiomata. Since that time acetate of peroxide of iron, hot water, alcohol, quinine hydrochloride and urethane, as well as innumerable other solutions, have been used. One-quarter to three c.c. of sodium morrhuate in five per cent solution is usually considered to be most advantageous, as recommended by Peyton and Leven,[4] as well as Watson and McCarthy.[1] Our experience with these methods has been somewhat limited and on the whole disappointing.

Unsatisfactory results from sclerosing solutions may occur as a result of sensitivity to the solution, in which case a generalized reaction may occur. Marked swelling usually ensues, and the possibility of infection and sloughs is always present. In hemangiomata in which the blood is circulating rapidly the sclerosing substances may be carried away before it has a chance to act.

4. Carbon Dioxide Snow.—Carbon dioxide snow was introduced as a freezing agent by Pusey in 1907, and still remains popular with dermatologists. Repeated applications of 7 to 10 seconds on small superficial hemangiomata of the hypertrophic endothelial type can be a satisfactory method of treatment. When too large a dose is used, blistering, and later scar formation, may occur as unsatisfactory results.

The most serious and most common error in the use of carbon dioxide snow is the attempted treatment of deep strawberry marks, or even cavernous hemangiomata. Under these circumstances the underlying tumor continues its destructive spread unchecked by the surface applications, even though the overlying skin may be treated so much as to show signs of damage.

5. Radiation Therapy.—Radiation, especially in the form of radium, is a most useful agent in the treatment of the hypertrophic endothelial or cavernous types of hemangiomata, if the proper method of application be employed. Since the sensitivity of vascular birthmarks to radium decreases inversely with the age of the patient, early treatment must be urged.

A. *X-ray Therapy.*—Many hemangiomata are exceptionally sensitive to radiation, and a trial of x-ray therapy is, therefore, sometimes warranted over very large lesions. Although Spencer[5] and others describe x-ray treatments as unfailing, this has not been our experience. We have caused large tumors to shrink by x-ray therapy, and have caused some of the smaller ones to disappear completely. In general, however, the results with x-ray have been less satisfactory than those obtained with radium.

Our results from x-ray therapy have not been uniform and have sometimes been disappointing, even when the dosage was raised to a point where the surrounding epiphyses, bones and other soft-tissue structures were getting amounts so large as to be a possible menace to normal growth.

Unsatisfactory results in the skin may be precipitated by small doses repeated too many times. Two cases treated elsewhere many years previously showed marked skin atrophy and malignant degeneration, which required excision and corrective surgery. For these reasons we are not satisfied with x-ray therapy alone for routine use in hemangioma therapy.

B. *Beta Rays of Radium.*—These rays are given off by unfiltered radium plaques or radon in glass applicators. They may be useful for small hemangiomata confined to the epidermal layers of the skin. The beta radiation which constitutes 96.5 per cent of the unfiltered radium output, is absorbed almost entirely by the superficial tissues and, therefore, has a very strong caustic effect on the outer layers of the skin. It is a dangerous mistake, therefore, to use unfiltered radium plaques for any but the most superficial lesions. If such beta ray therapy is employed for deeper lesions, unsatisfactory results may occur, because the skin may be severely

damaged, while the deeper portion of the hemangioma receives relatively little irradiation and, therefore, continues to grow.

C. *Gamma Rays of Radium.*—These penetrating rays which are provided by properly filtered radium pack, are most useful, and frequently even deep hemangiomata disappear with such treatment. Although the dose to the skin must necessarily be somewhat higher than the dose to the tumor with radium pack therapy, the depth dose is still satisfactory. Many hemangiomata are so sensitive that one or two doses of 700 to 1,000 gamma roentgens[6] will precipitate disappearance of the vascular tumor without damaging the skin. To obtain gamma rays we favor the use of filtered radium packs at distances of three millimeters for superficial lesions and one to three centimeters for deeper lesions. The radium must be arranged in a geometrical design, so that all portions of the tumor are irradiated as evenly as possible. To the filter of 0.5 mm. of platinum (which stops all of the beta radiation), are added 1 mm. of silver and 0.5 mm. of brass as secondary filters. The total filtration effect, therefore, is that of 1 mm. of platinum with 0.5 mm. of brass as a secondary beta ray filter.

We have not seen any undesirable results from properly filtered radium packs. Often the skin returns entirely to normal, but when it does not, the pliable pinkish-white scar which usually occurs instead is not unsightly.

D. *Radon Seeds.*—Gold-filtered radon seeds with a wall thickness of 0.2 mm. of gold and a strength of ¼ to ½ mc., can be planted in an appropriate geometrical arrangement so that there is one in every cubic centimeter of hemangioma tissue.[6] The radiation distribution is such that the skin gets less dosage than the lesion, if the seeds are planted sufficiently deep.

Frequently a single implantation of radon seeds will be sufficient to cause the hemangioma to disappear—a matter of considerable importance to patients who have come from a distance and who cannot return for numerous treatments. These tiny gold radon seeds are not removed from the tissues, but we have seen no unsatisfactory results on this account except when too many seeds were planted, or the implantations were too close to the surface.

Since radon seed implantation is a relatively simple process which frequently requires only one patient visit, it seems to us the method of choice in the therapy of the deeper hemangiomata, although we generally use heavy filtered radium packs in a preliminary attempt to determine whether the lesion is unusually radiosensitive in nature and may respond to this somewhat simpler type of treatment.

CONCLUSIONS

1. Prompt treatment of hemangiomata is indicated, because most types are more sensitive to treatment when the patients are very young. Although spontaneous regression occurs rarely, much valuable time is often lost in vainly waiting for it while the hemangiomata increase their invasive growth.

2. Unsatisfactory results in the treatment of hemangiomata are most frequently caused by the selection of the wrong agent for the particular type of hemangioma involved.

3. The "strawberry mark," and the even deeper type of cavernous hemangiomata, respond well to irradiation. Although x-ray is often satisfactory, the gamma rays of radium in the form of well filtered radium packs have given, in our experience, more uniform results. The implantation of weakly gold-filtered radon seeds permits a very favorable distribution of the radiant energy. For this reason, and because frequent repetition is not required as with other methods, radon seed implantation is often the therapy of choice.

2009 Wilshire Boulevard.

REFERENCES

1. Watson, William L., and McCarthy, William D.: S. G. and O., 71:569, 1940.

2. Figi, Frederick A.: Arch. Otolaryngol., 24:271, 1936.

3. Pravez, quoted by Peyton. (See below.)

4. Peyton, W. T., and Leven, N. L.: Surgery, 3:702, 1938.

5. Spencer, Jack: Am. J. Roentgenol., 46:220, 1941.

6. Report of the Research and Standardization Committee of the American Radium Society: Am. J. Roentgenol., 43:118, 1940.

SODIUM SULFADIAZINE IN THE TREATMENT OF MENINGOCOCCAL MENINGITIS*

LIEUTENANT JOHN B. McDONALD
Medical Corps, Reserve
AND
CAPTAIN CHESTER T. JOHNS
Medical Corps, Army of the United States
Camp San Luis Obispo

NO deaths resulted in ten cases of epidemic meningitis treated with sulfadiazine exclusively, although six of these patients were in coma for an average of twenty-seven hours. There were slight transitory drug reactions in seven cases and temporary complications resulting from the disease in only three cases, but all patients returned to full duty in one month.

It was not until the advent of chemotherapy in the treatment of cerebrospinal meningitis and the preliminary report of the use of sulfonamides in humans by Schwentker, Gelman, and Long[1] in 1937 that the mortality rate was reduced to 10 to 12 per cent. Since that time the mortality rate has steadily decreased with this type of therapy.

CLINICAL PATHOLOGY

Although we have no autopsy material among our cases, we are aware that the pathological process appears to be readily explained by a septicemia followed by diffuse fibropurulent exudate in the meshes of the pia over the convexity and base of the brain and about the cerebellum and spinal

* The opinions and assertions contained herein are the private ones of the writers and are not to be used as official or reflecting the view of the Army Department or the army service at large.

TABLE 1.—*Symptoms Report on Ten Cases of Cerebrospinal Meningitis**

Case Numbers	1	2	3	4	5	6	7	8	9	10
Age	26	24	19	25	20	20	19	19	22	22
Nasopharyngitis	—	+	+	—	—	+	+	—	—	+
Headache	+	++	++	+	++	+	+	+	+	+
Chills	+	+	+	+	+	+	+	+	+	+
Nausea and vomiting	+	+	+	+	+	+	+	+	+	+
Photophobia	+	+	+	—	+	—	—	+	—	+
Stiff Neck (subjectively)	—	+	—	+	—	+	++	—	—	—
Length of illness before hospitalization	36 hrs.	48 hrs.	24 hrs.	12 hrs.	24 hrs.	24 hrs.	48 hrs.	18 hrs.	24 hrs.	36 hrs.

* Symptoms of patients, in coma on admission, were obtained from Field Officers.

TABLE 2.—*Clinical Findings*

Case Numbers	1	2	3	4	5	6	7	8	9	10
Coma (length of time)	7 hrs.	—	24 hrs.	5 hrs.	—	—	—	*72 hrs.	*36 hrs.	*20 hrs.
Nystagmus, V Nerve	(Strabismus)	+	+	+	+	+	+	+	+	+
Conjunctivitis	—	+	++	—	—	+	+	—	+	—
Herpes labialis	—	—	+	—	—	—	++	—	—	+
Opisthotonos	—	—	—	—	—	+	+	—	—	—
Brudzinski	++	++	+	+	+	++	+++	+	+	+
Kernig	+	+	—	—	+	+	++	*?	*?	—
Hyperactive Tendon reflex	+	+	+	+	+	+	+	+	+	++
Babinski	—	—	—	—	—	—	—	—	—	—
Petechial rash, changing to purpura	—	+	+	—	—	+	—	+	++	—
Mild clonic twitching and hyperactivity	—	—	++	—	—	—	—	++	+	+
Temperature on admission	102°	102°	103°	104°	102°	99.6°	102°	104°	104°	101°
Tachycardia, followed by bradycardia	+	+	+	+	+	+	+	+	+	+

* In coma on admission.

TABLE 3.—*Laboratory Data*

Case Numbers	1	2	3	4	5	6	7	8	9	10
Blood count WBC	13,600 90-10%	30,000 84-14%	16,000 90-10%	29,800 87-13%	21,900 86-14%	30,100 89-14%	18,350 80-20%	23,500 84-15%	43,000 90-10%	29,800 90-10%
Urine	—	—	—	—	—	—	—	—	—	—
Kahn	—	+	—	—	—	—	—	—	—	—
Blood culture	—	—	—	—	—	—	—	—	—	—
Blood sugar	Normal	Normal	Normal	Normal	Normal	Normal	Normal	Normal	Normal	Normal
Nasopharyngeal culture	+	+	+	+	—	+	—	*	*	+
Spinal Fluid: Pressure	280	170	310	350	325	290	350	300	400	420
Queckenstedt—normal										
Appearance	Turbid	Turbid	Turbid	Turbid	Turbid	Turbid	Turbid	Turbid	Turbid	Turbid
Count	560+ Pellicle 98% poly	1,800 100% poly	2,179 94% poly	6,250 97% poly	11,000 96% poly	1,980 91% poly	10,000 95% poly	2,850 94% poly	13,350 96% poly	10,000 90% poly
Sugar	65 mg.	83.3 mg.	71.4 mg.	35.9 mg.	62.5 mg.	5.8 mg.	6.0 mg.	62.5 mg.	40.2 mg.	26.0 mg.
Globulin	Neg.	Neg.	Inc.	Inc.	Inc.	Inc.	Inc.	Inc.	Inc.	Inc.
Smear	In. & Ex. Cellular	Ex. Cellular	In. & Ex. Cellular	In. & Ex. Cellular	Neg.†	Ex. Cellular	In. & Ex. Cellular	In. & Ex. Cellular	In. & Ex. Cellular	In. & Ex. Cellular
Culture	Neg. fluid	Pos.	Pos.	Pos.	Neg.	Neg.	Pos.	Pos.	Neg.	Neg.

* Unable to take smear.

† This case is carried as cerebrospinal meningitis because chemotherapy was started thirty-six hours before we saw him, and therefore we were unable to isolate organism.

TABLE 4.—*Subsequent Urinary Laboratory Data*

Case Numbers	1	2	3	4	5	6	7	8	9	10
Acetyl Sulfadiazine crystals	0	+	+	+	0	+	0	+	0	0
R. B. C.	Many	0	Many	Many	Many	Many	0	Many	Many	0
Albumen	++	0	+	+	++	++	0	+	+	++
Final urinalysis	—	—	—	—	—	—	—	—	—	—

cord, thus accounting for the neurological findings. Temporary conjunctivitis (Table 2) occurred in five of our cases, probably due to trigeminal[2] nerve irritation or local presence of Gram-negative diplococci, which we feel may also account for marked photophobia seen in six cases. Nystagmus from irritation or brief paralysis of the oculomotor nerves was found in all cases. Temporary deafness in the left ear of one patient occurred following involvement of the eighth nerve. Purulent arthritis[3] and synovitis were important phenomena[4] in two patients, one involving only the elbow, while the other had multiple joints affected, including both knees and right elbow, due to the septicemia.[5] Fever, chills, leukocytosis, and variable petechial rash (see pictures) which later changed to purpura,[6] were noted in five cases and were also undoubtedly due to the septicemia. The onset of the illness was initiated by nausea and vomiting in all our cases, which we feel is a paramount symptom, and has never been fully explained, but is probably due to central irritation.

TREATMENT

Although no antimeningococcic serum or meningococcic antitoxin was used, our findings concur with present statistics, that chemotherapy is far superior in the treatment of cerebrospinal menin-

gitis to serum or antitoxin, and that sulfadiazine is the drug of choice. Serum therapy should be reserved for those patients who do not respond or are sensitive to the sulfonamides. Our patients did not fall into either category.

The fulminating nature of the disease requires emergency intravenous drug therapy immediately.

In the treatment we found the initial administration[7] of 5 grams of the sodium salt of sulfadiazine, in 1,000 c.c. of triple distilled sterile water, the best method of obtaining a high blood concentration early. This method of chemotherapy was forcibly impressed upon us by the first of six cases in coma which responded dramatically. We feel that not only the bacteriostatic action was accomplished, but also replacement of fluid lost in vomiting was obtained, and chances of renal complications obviated. In order to maintain an adequate blood level of the sulfonamide, we gave the second dose of one gram in two hours by mouth when possible, thus allowing for absorption time from the intestinal tract; otherwise in four hours intravenously. All subsequent doses of one gram were given every four hours. Although the temperature dropped by crisis in two or three days, this dosage was maintained in all cases for ten days. If the patient was symptom-free, the dosage was then divided into one-half gram every four hours for three days longer, and if at this time the patient was clinically well, the chemotherapy was withdrawn entirely,[8] except where complications intervened. This may be more concisely stated;[7] continuous drug therapy until temperature normal seven days. The average total dosage of sulfadiazine was 64 grams, and the blood level was between 5 and 12 milligrams per 100 c.c. of blood for the first two weeks. We feel that the slight toxic reactions of sulfadiazine and the negligible mortality rate makes sulfadiazine the choice of sulfonamides.

At least 3,000 c.c. of fluid was given daily either by mouth or, if parenterally, 3,000 c.c. of 5 per cent glucose in normal saline. Urinalyses were determined daily, but when albumen, red blood cells, or crystals of the acetyl compound were noted (Table 4), urine examination was then done on each consecutive specimen. Then fluids were further forced to 4,000 c.c. daily and one gram of sodium bicarbonate was given four times daily to maintain an alkaline urine, thus preventing the precipitation of acetyl-sulfadiazine.[9] No permanent kidney impairment resulted under this form of therapy and adequate blood levels were maintained for as long as three weeks in one case. Daily[10] complete blood counts were taken and no depression of consequence of the hematopoietic system occurred.

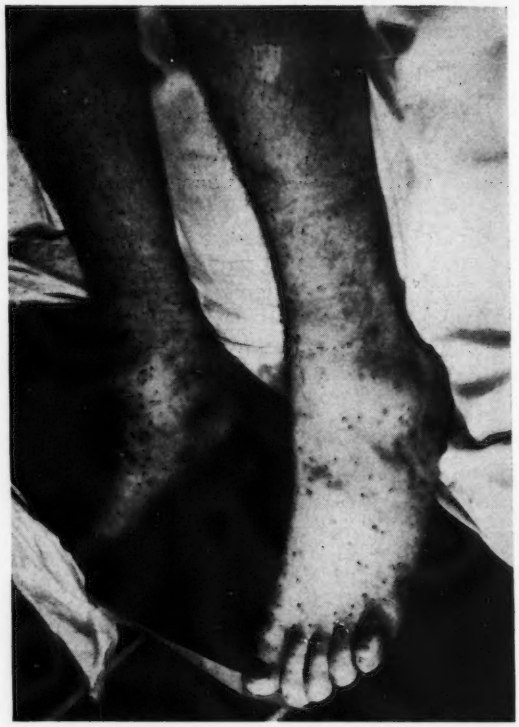

Fig. 2.—(Case 9) Petechial change after first twenty-four hours.

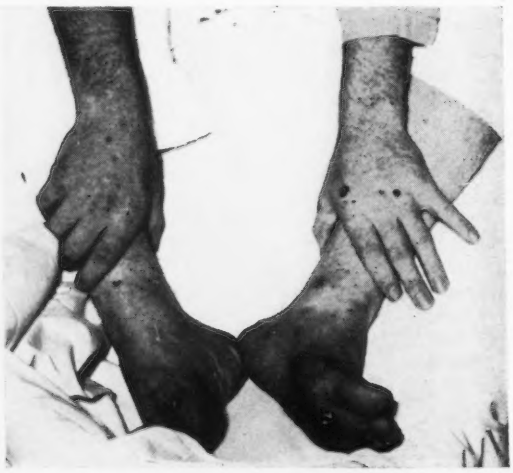

Fig. 1.—(Case 9) Petechiae after first twenty-four hours.

Blood sulfadiazine concentrations were made after the first twenty-four hours and continued on alternate days. Blood sedimentation rates were determined during convalescence, as we find from our 150 cases of chemotherapy-treated pneumonias it is an excellent criterion for complete cure before discharging soldiers to full field duty.

Chemotherapy in the treatment of cerebrospinal meningitis represents only one phase of the management of this condition. Early recognition of the symptoms (see Table 1) and prompt spinal fluid diagnosis (Table 3) are imperative. Isolation technique in a darkened quiet room offers the patient most comfort. Sedation proved to be one of the greatest problems; three of the six comatose patients had mild clonic twitchings or convulsive seizures for as long as seventy-two hours. Full restraints, even straitjackets were necessary, thus requiring alert nursing care and attention to bed

and restraint sores. It was found that the patients had a high tolerance to barbiturates, either intravenously or intramuscularly. The barbiturates were used with caution, because bradycardia followed the initial tachycardia (see Table 2). For nourishment 5 per cent glucose in saline was given to the patients in coma, and a soft diet was begun as soon as the patient was able to be fed.

Criteria for further spinal punctures were persistent clinical symptoms, or evidence of marked intracranial pressure; but in our cases there was no evidence of spinal subarachnoid block. Subsequent spinal taps at the time of discharge we found to be of no clinical value because of negative spinal fluid findings.

The routine requirement of three negative nasopharyngeal cultures, five days apart, before discharge, was followed. All patients were seen on admission and discharge by a member of the neuropsychiatric and the eye, ear, nose and throat departments.

COMPLICATIONS

The average length of hospitalization was one month, except in three cases where complications occurred. One patient (Case 7) had temporary deafness of the left ear, lasting five days. Purulent polyarthritis and synovitis were noted in another patient (Case 6), involving the right elbow and both knees. Fifty c.c. of cloudy, straw-colored fluid containing many polymorphonuclear cells was aspirated from these joints and cultured, but no meningococci were grown or seen on smears, probably due to previous bacteriostatic action of chemotherapy. In a third patient (Case 2) monoarthritis and synovitis with effusion of the left elbow developed. There were slight joint residuals clinically. The elbows affected in both arthritic cases have 15 per cent limitation of extension at the present time, but orthopedic opinion is that full function can be expected. X-ray failed to reveal skeletal changes of any permanent significance in any of the involved joints.

SUMMARY

1. No deaths resulted in ten cases of meningococcal meningitis treated with sulfadiazine exclusively, although six of these patients were in coma for an average of twenty-seven hours.

2. Constant clinical findings were: headache, nystagmus, chills, fever, nausea, vomiting, and positive Brudzinski, substantiated by laboratory findings of high blood leukocytosis and spinal fluid with high leukocytic cell count and intracellular or extracellular Gram-negative diplococci.

3. In treatment sulfadiazine is the drug of choice, because of the slight toxicity, low mortality, prompt recovery, and minimum of complications. Although no serum or antitoxin was used, we concur with present statistics that serum or antitoxin therapy should be reserved for those remote cases of drug idiosyncrasies and those who fail to respond to chemotherapy.

4. The fulminating nature of the disease requires the immediate administration of 5 grams of sodium sulfadiazine intravenously for the initial dose in all cases to obtain early high blood concentration. This should be followed by one gram every four hours intravenously if the patient is in coma or vomiting, otherwise sulfadiazine one gram orally for at least ten days. With our patients the average total dosage of sulfadiazine was 64 grams, and the blood level was between 5 and 12 milligrams per 100 c.c. of blood for two weeks. Renal and toxic complications may be obviated by ample fluids, daily complete blood counts, urinalysis, and sodium bicarbonate.

5. Complications of the disease in our cases were few with sulfadiazine and do not appear to be of a permanent nature, purulent arthritis and synovitis being most common. Without complications the average length of hospitalization was one month, discharge being based on three negative nasopharyngeal cultures taken five days apart and normal blood sedimentation rates. The latter we found, from our 150 cases of chemotherapy-treated pneumonias, to be an excellent criterion for complete cure before discharge to full field duty.

Station Hospital, Camp San Luis Obispo.

REFERENCES

1. Schwentker, F. F., Gelman, S., and Long, P. H.: J. A. M. A., 108:407 (April 24), 1937.

2. Cecil, R. L.: "A Textbook of Medicine, Cerebrospinal Fever." W. B. Saunders Company, p. 216, 1940.

3. Wechsler, Israel S., M. D.: "A Textbook of Clinical Neurology, Meningococcus Meningitis," W. B. Saunders Company, p. 398, 1940.

4. Christie, A. B.: An Unusual Meningococcal Relapse Syndrome, Lancet, 243:641 (Nov. 28), 1942.

5. Kilham, Lawrence: Meningococcal Septicemia with a Malarial Type of Fever, British Med. Jour., 2:696 (Dec. 12), 1942.

6. Watson, Alexander J.: Purpuric Type of Cerebrospinal Fever, British Med. Jour. 2:558 (Nov. 7), 1942.

7. "Guides to Therapy for Medical Officers," T. M. 8-120, para. 45 and 46, pp. 123-124.

8. Janeway, Charles A.: The Sulfonamides: I. Their Mode of Action and Pharmacology; II. Their Clinical Use, New England Jour. Med., 227:989, 1029 (Dec. 24 and 31), 1942.

9. Fox, C. L., Jr., Jensen, Ole J., Jr., and Mudge, G. H., Lt. M. C., U. S. A.: Prevention of Aenal Obstruction During Sulfadiazine Therapy, J. A. M. A., Vol. 121, No. 14 (April 3), 1943.

10. Finland, Maxwell, Peterson, Osler L., and Goodwin, Robert A: Sulfadiazine: Further Clinical Studies of Its Efficacy and Toxic Effects in 460 Patients, Jour. Annals of Internal Medicine, Vol. 17 (O. S. Vol. 22, Dec.), 1942.

Relief of Allergic Premenstrual Headache.—Certain allergic women who suffer from premenstrual headache, premenstrual tension, and associated dysfunctional ailments were found to have sharply positive reactions to intradermal testing with a gonadotropic preparation, a 1:5 dilution of Synapoidin. Numerous controls made negative responses. Women showing positive reactions were relieved by intradermal desensitization with the same preparation. This method of test and treatment is simple, harmless, and effective.—E. W. Phillips, Phoenix, in *Southwestern Medicine*, June.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

KARL L. SCHAUPP, M. D.....President
LOWELL S. GOIN, M. D.....President-Elect
E. VINCENT ASKEY, M. D.....Speaker
PHILIP K. GILMAN, M. D.....Council Chairman
GEORGE H. KRESS, M. D...Secretary-Treasurer and Editor
JOHN HUNTON.....Executive Secretary

EDITORIAL BOARD

Chairman of the Board:
Albert J. Scholl, Los Angeles

Executive Committee:
Lambert B. Coblentz, San Francisco
Fred D. Heegler, Napa
Albert J. Scholl, Los Angeles
George W. Walker, Fresno

Anesthesiology:
H. R. Hathaway, San Francisco
Ernest H. Warnock, Los Angeles

Dermatology and Syphilology:
William H. Goeckerman, Los Angeles
H. J. Templeton, Oakland

Eye, Ear, Nose and Throat:
Frederick C. Cordes, San Francisco
L. G. Hunnicutt, Pasadena
George W. Walker, Fresno

General Medicine:
Lambert B. Coblentz, San Francisco
L. Dale Huffman, Hollywood
Mast Wolfson, Monterey

General Surgery (including Orthopedics):
Frederic C. Bost, San Francisco
Fred D. Heegler, Napa
William P. Kroger, Los Angeles

Industrial Medicine and Surgery:
John D. Gillis, Los Angeles
John E. Kirkpatrick, Shasta Dam

Plastic Surgery:
William S. Kiskadden, Los Angeles
George W. Pierce, San Francisco

Neuropsychiatry:
Olga Bridgman, San Francisco
John B. Doyle, Los Angeles

Obstetrics and Gynecology:
Daniel G. Morton, San Francisco
Donald G. Tollefson, Los Angeles

Pediatrics:
William W. Belford, San Francisco
William C. Deamer, San Diego

Pathology and Bacteriology:
Alvin J. Cox, Jr., San Francisco
R. J. Pickard, San Diego

Radiology:
R. R. Newell, San Francisco
Henry J. Ullmann, Santa Barbara

Urology:
Lewis Michelson, San Francisco
Albert J. Scholl, Los Angeles

Pharmacology:
W. C. Cutting, Menlo Park
Clinton H. Thienes, Los Angeles

† For complete roster of officers, see advertising pages 2, 4, and 6.

OFFICIAL NOTICES

COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Three Hundred Thirteenth (313th) Meeting of the Council of the California Medical Association*

The meeting was called to order in conference room 8 of the Biltmore Hotel, in Los Angeles, at 10 a. m. on Sunday, October 10, 1943.

1. Roll Call:

Councilors present: Philip K. Gilman, Chairman; Karl L. Schaupp, Lowell S. Goin, William R. Molony, Sr., E. Vincent Askey, E. Earl Moody, Edwin L. Bruck, Sam J. McClendon, Edward B. Dewey, Calvert L. Emmons, Donald Cass, Harry E. Henderson, Axcel E. Anderson, R. Stanley Kneeshaw, John W. Cline, Lloyd E. Kindall, Frank A. MacDonald, John W. Green, and Secretary George H. Kress.

Councilor absent: Dewey R. Powell.

Present by invitation: L. A. Alesen, Vice-Speaker; Dwight H. Murray, Chairman of Committee on Public Policy and Legislation; Harold A. Fletcher, and Edward M. Pallette, California Chairmen on Procurement and Assignment for Physicians; A. E. Larsen, Secretary of California Physicians' Service; Clifford W. Mack, President of California Hospital Association; B. O. Raulston, Dean of University of Southern California School of Medicine; Eugene F. Hoffman, Assistant Medical Director, California Physicians' Service; Mr. John Hunton, Executive Secretary; Mr. Hartley F. Peart, Legal Counsel; Mr. Howard Hassard, Associate Legal Counsel; Mr. Ben Read, Secretary of California Public Health League; Wilton L. Halverson, Executive Officer of California State Board of Public Health; and Mr. Clifford Walker, Hospital Service of Southern California.

2. Minutes:

Minutes of the following meeting of the Council were submitted and approved:

(*a*) San Francisco meeting (312th) held on August 22, 1943. (Abstract printed in CALIFORNIA AND WESTERN MEDICINE, September, 1943, pages 170-173.)

3. Membership:

(*a*) A report of membership as of October 9, 1943, was submitted and placed on file.

(*b*) On motion duly made and seconded, it was voted that twenty members whose dues had been paid since the last Council meeting, held on August 22, 1943, were reinstated.

(*c*) Upon motion duly made and seconded, retired membership was granted to the following members, whose applications had been received in duly accredited form from their respective county societies: William T. Rothwell, Los Angeles County; Ernest Dwight Chipman, San Francisco County.

4. Financial:

(*a*) A report of finances as of October 9, 1943, was submitted and placed on file.

* Reports referred to in minutes are on file in the headquarters office of the Association. Minutes as here printed have been abstracted.

(*b*) Report was made concerning income and expenditures for September and for nine months, as of September 30, 1943.

(*c*) A balance sheet as of September 30, 1943, was submitted.

Upon motion duly made and seconded, the above reports were received and placed on file.

5. **Public Relations Survey:**

A report of the Special Committee on Study of Public Relations (Doctors Askey, Cline, and MacDonald) was made by its chairman, E. Vincent Askey. Doctor Askey informed the Council concerning conferences with representatives of a nationally known firm whose members specialize as public relations advisors and councilors.

Mr. Jack Little, a representative of the public councilors firm of Foote, Cone and Belding, successors to the well-known Lord and Thomas group, then addressed the Council, outlining a skeleton plan of procedure that would be put into operation if the group he represented should be called upon to do the work. The survey would be presumably carried through in the name of the California Institute of Public Opinion, it being estimated that at least 5,000 personal interviews would be necessary in order to acquire a good cross section of California lay public opinion concerning the medical profession of the State and its own and public health work. This initial or preliminary survey would be made on a cost basis.

It was emphasized that it was desirable that, if such a plan was to be put into operation, time was somewhat of the essence and the planning should begin at an early date.

Discussion was participated in by Doctors Cline, MacDonald, Molony, Dewey, and other councilors.

Dr. Clifford Mack, President of the Association of California Hospitals, was invited to speak and stated he felt sure the hospital groups would be in full accord and hoped that it would be possible for the State Medical Association and the State Hospital group to work together in close interest.

Further discussion was participated in by Mr. Clifford Walker of the Hospital Service of Southern California, Dr. Dwight Murray of the California Medical Association Committee on Public Policy and Legislation, and others.

Doctor Molony mentioned a somewhat similar survey which had been undertaken by the National Physicians' Committee.

Upon motion by Cass, seconded by Goin, it was voted that the firm of Foote, Cone and Belding be employed to make the proposed survey. Dr. Axcel Anderson requested that his vote be recorded as opposed.

Mention was made of the fact that other public relations groups had been consulted, but that in this particular work it was believed the firm selected was in the best position to carry through. (Note: For editorial comment, see p. 255.)

6. **California Physicians' Service and Hospitalization Organization Liaison Activities:**

The Special Liaison Committee, consisting of Doctors Cline, MacDonald, and Dewey, submitted a report through its chairman, Doctor Cline.

Full discussion followed: Councilor MacDonald was reluctant to accept some of the changes that were a variation from the recommendations in the Mannix report. President Schaupp and others commented on special phases of the work. (Note: For editorial comment, see p. 253.)

The report, in its final form, follows:

CALIFORNIA PHYSICIANS' ACTIVITIES WITH REFERENCE TO COMBINATION WITH THE HOSPITALIZATION GROUPS

Part I—Initial Statement

A Council Committee, consisting of Doctors Frank MacDonald, Edward Dewey, and John W. Cline, appointed by Chairman Gilman, was limited in the scope of its investigation to consideration of the best means of accomplishment of the union between California Physicians' Service and a state-wide hospitalization company which is to be formed. This union is to be accomplished in the general lines of the Mannix report which has already been approved with modifications by the Council of the California Medical Association. Mr. Mannix has accepted such modifications and incorporated them as his own.

The recommendations of the Mannix report are ten in number:

1. The first recommendation concerns only the Hospital Service Plan.

2. We feel that recommendation No. 2 should be accepted by California Physicians' Service with one modification. It seems increasingly probable that the executive chosen by the Executive Committee would be a layman. It, therefore, would seem wise to have a medical director who would deal with purely professional matters, serving in an independent position and directly responsible to the Board of Directors of California Physicians' Service by way of the medical members of the Executive Committee. Otherwise, the second recommendation should be fulfilled by California Physicians' Service in its entirety.

3. The third recommendation, we believe, should be followed by California Physicians' Service in its entirety. This would result in reduction of overhead and greater efficiency of operation.

4. The fourth recommendation, which segregates professional services from the nonprofessional services, usually performed by hospitals should be carried out, and California Physicians' Service should issue a separate contract covering x-ray, medical anesthesia, and pathological laboratory services.

5. The fifth recommendation, which urges a detailed actuarial study of the plans now existent, is desirable and should be carried out if sufficient experience is available to warrant sound actuarial conclusions. It would be foolish to undertake an actuarial study unless the data be sufficient to warrant reliable conclusions. This is a matter which must be determined by actuaries themselves.

6. The sixth recommendation applies to the Hospital Plan directly, but also has an indirect effect upon the economic structure of California Physicians' Service. It is hoped that the hospitals and the Hospital Plan will cooperate in this matter.

7. The seventh recommendation, suggesting the expansion of California Physicians' Service and the new Hospital Plan to the States of Arizona and Nevada, has merit. It is desirable to have the activities of a voluntary prepayment medical plan in these states, but California Physicians' Service should not expand into such areas without agreement by the medical profession of these two states.

8. The eighth recommendation urges that all physicians agreeing to practice under the plan, and all hospitals agreeing to furnish service under the plan should contract to do so for a period of one year. It seems undesirable to limit the duration to one year, and we would suggest that such agreement continue indefinitely unless canceled after a minimum period of one year.

9. The ninth recommendation includes advisable methods of enlisting support of the public and giving the public a voice in the conduct of the affairs of both the hospitalization and medical plan. This seems highly desirable.

10. The tenth recommendation is likewise in the line of public relations and should be carried out.

* * *

Part II—Comment and Recommendations

The above recommendations are all based upon the assumption that a union between the consolidated single state-wide Hospital Plan and California Physicians' Service be

accomplished. California Physicians' Service should make every effort to meet with and assist in the development of plans for the consummation of this object. We believe that it is inadvisable for California Physicians' Service to remain aloof until the Hospital Plan has been unified. California Physicians' Service should at once signify its intention of uniting with the unified Hospital Plan and should coöperate in every way to facilitate the merger of the three now existing plans.

It must be realized that the projected plan will not be immediately accomplished and that the three hospitalization organizations and California Physicians' Service have responsibilities which they have contracted to discharge. It will be necessary for all these to protect themselves and their subscriber members under the terms of their organizations and contracts.

It is our opinion that the coöperative venture will succeed only if designed for mutual advantage. It cannot be expected that the combined organization contemplated can continue operation if there is an effort on the part of California Physicians' Service or the Hospitalization Plan to take advantage of the other. In order to insure equity in the details of the organization, and with particular reference to financial allotment, it is suggested that a group of three public-spirited and fair-minded individuals, who have no direct interest in either organization and no preëxisting prejudices, should be chosen by the usual means of setting up arbitrating commissions. We further believe that California Physicians' Service and the Hospital Service Plan should make every effort to establish the joint organization by coöperation, conference, and negotiation. They should mutually bind themselves to submit to and abide by the decisions of the arbitration committee upon any matter in which agreement cannot be reached. We believe that in this way an impartial and unprejudiced arrangement can be made to protect the interests of all concerned.

In accomplishing the unification of the three hospitalization groups in California (Hospital Service of California, Hospital Service of Southern California, and Intercoast Hospitalizatior Insurance Association) and California Physicians' Service, it will be necessary for each organization to make extensive changes in by-laws and articles of incorporation.

It is suggested that in this process, California Physicians' Service should eliminate the present cumbersome method of choice of trustees and substitute therefor a plan of election which would create a board which would be more immediately responsive to the wishes of the professional members than is possible under the present plan. To this end the State should be districted and each geographical district should be represented. Representation should be in proportion to the number of professional members in each district, and reapportionment should be made at intervals of about three years. The method of election should be given careful thought, and consideration should be given to the desirability of choice of trustees of California Physicians' Service by the House of Delegates of the California Medical Association, the component county societies, or the Council of the California Medical Association. Under any plan, direct Council representation should be provided. To this end a specified number of trustees should probably be chosen by and from the Council of the California Medical Association..

* * *

Of recent date it has become increasingly evident that it would not be possible to accomplish the unification of the hospitalization plans and the amalgamation of a state-wide plan with California Physicians' Service by voluntary effort alone. Due to the pressure of the practice of physicians and the occupation of hospital executives with difficulties of administration, it appears that the project will fail unless other means are adopted.

It is, therefore, recommended:

1. That a ten-member committee be appointed consisting of:

(a) Three members of the California Medical Association Council, namely, the President, President-Elect, and Chairman of the Council;

(*b*) The President of the Association of California Hospitals and two members of the Board of Trustees designated by him;

(*c*) One representative appointed by and from the Boards of Directors of each of the hospitalization organizations, *i. e.*, Hospital Service of California, Intercoast, and Hospital Service of Southern California;

(*d*) One representative appointed by and from the Board of Trustees of California Physicians' Service.

2. That this Committee be empowered to employ a full-time executive secretary to work out the details of organization and do the actual work involved under the direction of the Committee, which should determine the policies to be followed in effecting the organization.

It is suggested that such an individual should be employed to accomplish the actual organization and that no offer of permanent employment be made until the work has been completed, but that in choosing the man to accomplish the groundwork, the Committee should bear in mind that, if satisfactory to all concerned, he might be the logical person to become the executive secretary of the combined organization.

It would seem preferable to choose a man from outside the State of California because of freedom from local prejudice.

Beyond these suggestions there is no intention of the California Medical Association Council to influence the choice of or the exact duties of such an organizer.

3. That the Council of the California Medical Association appropriate funds necessary to employ such a full-time executive secretary and establish an office in which he could work for a period of not less than three nor more than twelve months.

Respectfully submitted,

SPECIAL LIAISON COMMITTEE OF C. M. A. COUNCIL

By Dr. John W. Cline, Chairman
Dr. Frank A. MacDonald
Dr. Edward B. Dewey

* * *

Upon motion by Goin, seconded by Green, it was voted that the report of the Special Committee be received and its recommendations be accepted.

Upon motion by Cline, duly made and seconded, it was voted that the Council appropriate $1,500 a month for a period of three months to finance the organization work of unification of the hospitalization plans and California Physicians' Service; the Executive Committee of the California Medical Association to have the authority to extend the appropriation for a longer period if necessary, and to appropriate additional funds in any month to meet unforeseen expenses.

7. California Bureau of Vocational Rehabilitation:

The courtesy of the floor was granted to Mr. H. D. Hicker, Chief of the Bureau of Vocational Rehabilitation of the California State Department of Education. Mr. Hicker stated that the State Bureau was anxious to have the coöperation of the medical profession in its rehabilitation work among crippled citizens.

After discussion, upon motion duly made and seconded, it was voted that the Chairman of the Council be authorized to appoint a Special Advisory Committee of five members to the California Bureau of Vocational Rehabilitation. Committee consists of Drs. J. B. Harris, Sacramento, Chairman; E. Vincent Askey, Los Angeles; Gertrude

Moore, Oakland; John W. Cline, San Francisco; and L. C. Kinney, San Diego.

8. **Federal Children's Bureau Maternity and Pediatric Plan:**

The Federal Children's Bureau plan to provide maternity and pediatric service to the wives and infants of enlisted men, which had been discussed in previous Council meetings, was brought up for discussion. (References to former actions thereon: (*a*) 311th Council meeting of June 19, 1943, Item 7, pages 72-73, July issue of Calif. & West. Med.; (*b*) page 83, July Calif. & West. Med., letter sent to component county societies by Council Chairman Gilman; (*c*) 312th Council meeting. Item 5(a) page 171, September Calif. & West. Med.)

Resolutions of component county societies concerning the maternity and pediatric program of the Federal Children's Bureau (Sacramento, Yolo, Contra Costa, Solano, and Santa Clara counties) were submitted.

Wilton L. Halverson, Executive Officer of the California State Board of Public Health, was asked to discuss the subject of maternity and pediatric work in relation to the Federal Children's Bureau program.

Doctor Halverson stated that the Federal Children's Bureau had placed the responsibility of administration of its program upon the California State Board of Public Health, but that the Board of Health had been obliged to use its own funds for clerical and other services incident to carrying through the program.

In thirty-eight counties of California the program was in operation, and 150 hospitals had expressed willingness to participate, and of that number about three-fifths had submitted the necessary auditing statements concerning their maintenance costs, the same to be sent forward to Washington, D. C.

Doctor Halverson outlined the grants-in-aid which had been made, and stated that in October it was estimated that 3,000 obstetrical cases would be submitted in California, with an estimated appropriation need of $339,000. It was possible that there might be 30,000 obstetrical cases coming under this program during the year. If so, a three-million-dollar grant-in-aid would be needed to finance the service in California, the average cost thus far being $113; this being about $28, or 34 per cent above the average of cost procedures in other portions of the United States.

This allocation of medical care responsibility had been thrust upon the California State Board of Public Health, which primarily is interested in preventive medicine and not in medical care procedures. The responsibility had been accepted because of its emergency nature.

Doctor Halverson stated that the literature put out by the California State Board of Public Health calls attention to the fact that it is possible to carry on this work only because the members of the medical profession are themselves making generous donations in service, and that the financial compensation of the Federal Children's Bureau does not cover the costs for the professional services rendered.

The Council did not change its action previously taken wherein the decision concerning participation in the Federal Children's Bureau plan was left to individual members of the State Association. In regard thereto, the situation is as follows:

1. The California Medical Association has expressed approval of the objective to provide adequate maternal-pediatric care to the wives and infants of enlisted men;

2. The Council of the California Medical Association has *not* given approval to the regulations of the Federal Children's Bureau whereby the payments *must* be made to the attending physician;

3. Members of the California Medical Association are free agents in this work; each physician to decide for himself under what conditions he is willing to give the indicated professional services.

Since the physician has the privilege of deciding for himself whether he will or will not participate in the plan outlined by the Federal Children's Bureau, the following additional information is given:

(*a*) A physician is at liberty to sign Part II of the prospective mother's application (which she obtains from a local board of health, the same being a State Board of Health form), but in so doing, the physician obligates himself to give the professional services stipulated for the money consideration also outlined. Further, the physician agrees that he will not accept additional compensation for the said services from the patient or patient's family. Provided, that services rendered prior to the day the prospective mother signed the application, or for services not stipulated in the prenatal, confinement and postpartum agreement, may be charged against the patient. (It is important that the physician read the agreement and inform himself concerning the services he will be called on to render before he signs a prospective mother's application.)

(*b*) Members of the California Medical Association are also free to determine for themselves whether they will accept such patients as private patients, under agreements mutually agreeable between patient and physician; but in such cases the physician must refrain from signing the agreement which the health boards give to prospective mothers who make request therefor.

However, if this latter course of a personal arrangement is followed, it is important to remember that the prospective mother will not be entitled to hospitalization or other benefits included in the Federal Children's Bureau program.

9. **Industrial Accident Commission — Industrial Fee Schedule:**

Legal Counsel Peart made an oral report concerning conferences with representatives of the California State Industrial Accident Commission. He stated that the petition of the California Medical Association in which request is made for a revision of the fee schedules pertaining to professional services rendered by physicians is still under consideration. He stated that many factors enter into the problem. Because of changes in the State Board, it is somewhat difficult to secure a prompt decision in the matter.

10. **Osteopathy in California:**

Report concerning conferences with representatives of the Los Angeles College of Osteopathy was made by Councilor Goin. Council Chairman Gilman reported on the conference of September 30 which was had with the deans of the four Class A medical schools of California.

Dean B. O. Raulston of the University of Southern California School of Medicine reported on conferences with Los Angeles representatives and discussed also the rules of the Council on Medical Education of the American Medical Association and of the Association of American Medical Colleges, since it would be necessary to secure from these groups, approvals of proposed plans.

Report was made upon the informal suggestions made by the committees and representatives of the Los Angeles College of Osteopathy, the Osteopathic Association, and of the Alumni groups of the College.

Upon motion by Goin, seconded by Kneeshaw, it was voted that, if the California Osteopathic Association appoints a committee to take up the matters that have been the subject of discussions, the Chairman of the Council of the California Medical Association shall be authorized to appoint a similar committee to meet with the osteopathic committee in conference, for the purpose of discussing ways and means whereby further progress may be made in these matters.

Doctor Moody thought that time was of the essence in these matters, and submitted a motion, duly seconded, as follows:

Resolved, That the California Medical Association advocates union of the medical and osteopathic professions and that conferences toward that end be instituted, and that mutual steps be taken by the California Medical Association and the California Osteopathic Association to contact constituted authorities having relation to these matters in order that such union may be brought into being.

It was agreed that the committee previously appointed, consisting of Doctors Cline, Dewey, and Mr. Peart, be authorized to put the phraseology of the above resolution into proper form.

11. Procurement and Assignment:

Edward M. Pallette of Los Angeles was invited to address the Council concerning Procurement and Assignment Service activities. Doctor Pallette outlined the problems which had confronted Dr. Harold A. Fletcher and himself and stated that in his own group of fourteen southern counties a survey of civilian physicians had been made and that only in a few instances did conditions exist whereby the health of citizens in certain communities was in danger. He stated that every effort was being made to make available for the military forces physicians whose services in civilian practice could be spared.

12. Housing Projects in War Industry Areas:

A. E. Larsen, Secretary of California Physicians' Service, was invited to address the Council and outline the situations now existing in the Housing Project areas in San Diego, Alameda, and other counties.

Doctor Larsen informed the Council concerning a recent visit to Washington, D. C., and of other steps that had been taken.

It was stated that California Physicians' Service, which had been providing medical care in certain housing areas, had notified the Federal and local Housing Authorities that its contract to give such service would be terminated as of September 30, 1943.

In Washington the Federal Authorities made an emergency agreement for a sixty-day period under which California Physicians' Service would continue to give professional care; the new contract, however, exempting California Physicians' Service from certain types of medical service, such as obstetrics and certain surgical work. The arrangement was referred to as "Plan A."

The relative number of tenants who had signed for the California Physicians' Service service in the different areas was brought out and the complications which had arisen in connection with physicians in private practice who were called upon to give medical care in the housing areas, and likewise in relation to county society actions, were discussed.

Doctor Larsen stated that the commercial program of California Physicians' Service was going forward in good fashion; that the rural aid program had bright prospects, but that in the war industry areas, such as exist in the Housing Projects, it was not possible to forecast the future situations which may arise.

Councilor McClendon spoke at some length concerning the San Diego situation and the complications which had arisen in relation to California Physicians' Service and the general attitude of the local Housing Authorities in that area, which seemed to be not favorable to physicians in private practice. He stated he regretted to inform the Council that California Physicians' Service was not in much favor with the medical profession in San Diego County.

Councilor Green recounted the history of California Physicians' Service activities in the Vallejo area of Solano County and spoke of the conferences which had been held and the communications which had been received from the Housing Authorities.

Doctor Green stated, in criticism of California Physicians' Service, that it had failed to keep the county society informed when changes of considerable moment were made and that this had led to misunderstandings. Reference was made to the original agreement between the Solano County Medical Society and California Physicians' Service at a meeting of the California Medical Association Executive Committee held in Vallejo on September 8, 1942. (Reference in CALIFORNIA AND WESTERN MEDICINE for October, 1942, on page 248.)

13. Committee on Public Policy and Legislation:

Dwight H. Murray, Chairman of the Committee on Public Policy and Legislation, discussed the Wagner-Murray-Dingell bill (S. 1161; H. R. 2861). General discussion followed.

The suggestion was made that if the representatives of the Committees on Public Policy and Legislation of the constituent state associations of the eleven Pacific States could hold a conference it might be of real value in securing organized and harmonious coöperation from Congressmen of these eleven commonwealths.

Doctor Murray also stated that Mr. Ben Read, Secretary of the California Public Health League, was planning a visit to Washington, D. C., to get first-hand information concerning certain public health and medical practice measures, and that in due course reports would be submitted to the Council.

Upon motion by Schaupp, duly seconded, it was voted that the California Medical Association Council give its approval to the plan of having Mr. Read go to Washington.

14. Resolution on National and State Policy Administration with Report to California Medical Association House of Delegates:

Councilor Bruck introduced the following resolution:

Resolution

WHEREAS, The medical profession in America finds itself facing the most critical period in its existence; and

WHEREAS, The failure of maintenance of proper contact groups at the national capital, and the substitution therefor of feeble personal effort, has been a contributing cause to the conditions in which the medical profession finds itself; and

WHEREAS, Because of lack of understanding of basic issues and problems by certain officers of the American Medical Association, public opinion is ever turning against organized medicine; and

WHEREAS, These changes in public opinion allow various and certain pressure groups to advance their own selfish causes; and

WHEREAS, The political adherents of socialized medicine have seized upon the rising tide of public criticism against organized medicine in an effort to accomplish their own desires; and

WHEREAS, The unnecessary continuous defensive position of the officers of the American Medical Association makes it impossible for them to take leadership in bringing about proper general understanding of the real public needs with respect to medical care and progress; and

WHEREAS, The officers of the American Medical Association should long ago have taken a more constructive and aggressive lead in the study and organization of properly-conducted, medically-controlled, prepaid medical care plans, but have not done so, and instead have found themselves placed in an increasingly bad defensive position; and

WHEREAS, It is our belief that the archaic attitude of certain of the officers of the American Medical Association

regarding future conduct of medical practice and care of the public health is born of lack of foresight, or of an overestimate of their ability to fend off any deviation from past practices; and

WHEREAS, All of the foregoing has a great influence on the part that medicine must play in postwar planning in order that control of health and medical care be placed in the hands of the experts, in this case, namely, doctors of medicine; now, therefore, be it

Resolved, By the Council of the California Medical Association that there shall be placed before the next House of Delegates of the California Medical Association a request that this Association's delegates to the American Medical Association House of Delegates urge the following action by that House of Delegates:

1. The replacement of certain of the officers of the American Medical Association, to include the secretary and the editor of the Journal;

2. That a contract for suitable and proper survey of public opinion regarding its attitude toward organized medicine, medical care and proposed medical legislation be undertaken;

3. That an analysis of such information obtained by a qualified corps of experts outside of the American Medical Association be made;

4. That the information and instruction received through such surveys and analyses be properly used and not discarded (in order to attempt to mould public opinion into proper form);

5. That a suitable contact organization be set up at the national capital to try to regain that confidence of the legislators which the medical profession has enjoyed in the past; and be it further

Resolved, That a copy of this resolution be sent all other delegates to the American Medical Association before the next session of the House of Delegates of the American Medical Association, with a plea to further the above actions in the House of Delegates of the American Medical Association.

* * *

Upon motion by Bruck, seconded by Cass, it was unanimously voted that the resolution be accepted and approved in substance, but that Councilors Bruck, Kneeshaw, and Legal Counsel Peart be authorized to make such changes in phraseology as may be deemed desirable.

15. Agricultural Workers' Health and Medical Association:

President Schaupp, who has been a member of the Board of Directors of the nonprofit, semi-governmental corporation known as the "Agricultural Workers' Health and Medical Association" since the work of providing medical care for migratory agricultural workers was instituted some years ago, addressed the Council and called attention to Section 3 of Public Law 45 (78th Congress, Chapter 82, First Session, H. J. Resolution 96).

He stated that the existing language of Section 3 (a) (2) which now reads "furnishing by loans or otherwise, of health and medical and burial services, training, subsistence, allowances, protection, and shelter for such workers and their families" should be supplemented with the following additional language "provided further that funds available to the Administrator may be used for providing health and medical services to other migratory workers and their families who have entered the area without recruitment or assistance of any government agency and have engaged in agricultural work and to whom adequate health and medical services are not otherwise available in the area where they are working." So that in entirety the new wording will read as follows:

Section 3 (a) (2) furnishing, by loans or otherwise, of health and medical and burial services, training, subsistence, allowances, protection, and shelter for such workers and their families; *provided further that funds available to the Administrator may be used for providing health and medical services to other migratory workers and their families who have entered the area without recruitment or assistance of any government agency and have engaged in agricultural work and to whom adequate health and medical services are not otherwise available in the area where they are working.*

Doctor Schaupp stated further that the present wording of the Act is so restrictive that it excludes from medical care all agricultural workers who do not receive their employment as a result of some activity of some of the government agencies financed by Public Law 45. This means that our own American agricultural workers who have sufficient initiative and ingenuity to develop employment resources of their own are denied medical assistance.

Upon motion duly made and seconded, it was voted that a communication, calling attention to the desirability of an amendment to Public Law 45, be sent in the name of the Council of the California Medical Association to the California Congressmen, requesting their support of the proposed amendment. (For editorial comment see p. 256.)

16. Resolution Concerning Plan for Medical and Hospital Care of Citizens in Low Income Bracket Groups:

Councilor Kneeshaw brought to the attention of the Council the need of the medical profession to develop a positive program for medical and hospital care of citizens in the low income bracket groups. This was particularly indicated because of the militant activities of proponents of plans of socialized medicine and allied interests.

Upon motion by Kneeshaw, seconded by Bruck, it was voted that a committee be appointed by the Council Chairman to study and develop plans for medical and/or hospital care of citizens in low income bracket groups, the Committee to submit such plan or plans in a report for consideration by the California Medical Association Council; it being understood that the Council would submit a supplementary report with its recommendations to the House of Delegates of the California Medical Association in which the delegates of the California Medical Association to the House of Delegates of the American Medical Association would be instructed to submit a proper resolution in regard to the principles involved to the House of Delegates of the American Medical Association in the hope that the national body representing organized medicine would, in turn, formulate a constructive plan in which harmonious programs would be outlined that could be carried through by the constituent state associations of the American Medical Association. Committee consists of R. Stanley Kneeshaw, San Jose, Chairman; Edwin L. Bruck, San Francisco; John W. Cline, San Francisco; Karl L. Schaupp, San Francisco; and William R. Molony, Sr., Los Angeles.

17. Permanente Foundation Hospitals:

Councilor Emmons called attention to conditions which had come into being in connection with the hospital erected for the care of workers in the Fontana Steel Mills of the Kaiser interests, located in San Bernardino County. The hospital was operating as one of the activities of the Permanente Foundation. (References in Council minutes to Permanente Foundation: CALIFORNIA AND WESTERN MEDICINE for December, 1942, on pages 344-345; for January, 1943, on pages 23-26.)

The complications which had arisen in connection with practice by the contract physicians operating in this hospital of the Permanente Foundation and members in private practice, and with relation to future disposition and possibilities were mentioned.

Upon motion by Kindall, seconded by Emmons, a committee consisting of Councilors Kindall, Emmons, and Bruck, was appointed to make a study and report to the Council concerning the Permanente Foundation activities with special relation to medical staff activities and affiliations.

18. **Time and Place of Next Meeting:**

Upon motion duly made and seconded, it was voted that the time and place of the next meeting of the Council be left to the decision of the Council Chairman.

19. **Adjournment.**

PHILIP K. GILMAN, M. D., *Chairman*
GEORGE H. KRESS, M. D., *Secretary*

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

Acute Shortage of Doctors Is Feared

Signs indicate that the doctor shortage will grow more acute than ever, *The Journal of the American Medical Association* said recently.

On the basis of a survey by the U. S. Public Health Service, the War Manpower Commission, the Federal Works Agency, and the procurement and assignment service, it is stated that the armed forces have commissioned only slightly more than 80 per cent of their stated needs.

In addition, 80 per cent, or about 1,500 of the annual doctor output of the medical schools will be absorbed into service.

Even if the 1,500 remained and went into civilian practice, they would replace not more than half of the 2,500 to 3,000 doctors who die every year.

Mortality Statistics in World Wars I and II

There is no such thing as a nice war, and the allied powers have given up any idea of concealing its horrors from their people, but one particular horror of past wars has been reduced to a minimum in this one. The wounded soldier has a better chance.

The miracles performed by Army and Navy doctors and laboratory scientists have been mentioned before, and Rear Admiral Ross T. McIntire, Surgeon-General of the Navy and personal physician to President Roosevelt, has given some new information concerning them.

In the last war, 7 per cent of the men wounded in action died; in this war barely more than 2 per cent. That means that a wounded man has forty-nine chances to one in his favor in his fight to recover. And "recovery" means more than just living. Admiral McIntire says that, of the compound fracture cases in the last war, 12 per cent died and almost half were permanently crippled, while in this war not more than one per cent die and only 10 per cent will be disabled.

Blood plasma, sulfa drugs, penicillin, and speedy treatment tell the story, according to Admiral McIntire. They do not end the horror of war, but they are saving the lives and health of thousands of wounded who would have died or become helpless invalids in past conflicts.

Eye Defects Cause of Many Rejections

Army rejections among 18- and 19-year-olds are caused chiefly by eye defects among white youths and education deficiencies among Negroes, according to a report made by Colonel Leonard G. Rowntree of the Army Medical Corps Reserve; Kenneth H. McGill, and Thomas I. Edwards of Washington, D. C. It was based on record of induction centers in December, 1942, and January and February, 1943.

The report said 23.8 per cent of white youths were rejected and 45.5 per cent of the Negro youngsters.

Other than eye defects, reasons for rejection of white youths were, in order of occurrence: mental disease, muscle and bone defects, heart and blood defects, ear defects, hernia, neurological defects, educational deficiency, underweight, and mental deficiency.

The nine remaining causes for Negro rejections were: syphilis, heart and blood defects, mental disease, muscle and bone defects, hernia, eye defects, neurological defects, mental deficiency, and tuberculosis.

War Impairing Flyers' Hearing

In a speech before the national meeting of the American Academy of Ophthalmology and Otolaryngology, Dr. Walter Hughson of the Otological Research Laboratory, Abington, Pennsylvania, estimated there would be 250,000 cases of impaired hearing among service men resulting from the war.

"At the close of World War I there were an estimated 40,000 aural casualties of all degrees of hearing impairment," Doctor Hughson said.

"At the present moment there are six times as many men in the American armed forces as there were in the last war, and these scattered over the entire globe. On a purely numerical basis we may expect 250,000 aural casualties in this war. That the actual number will be much greater can hardly be questioned."

Asserting the medical treatment of deafness "is relatively unimportant and ineffective," he said it would be unlikely that any acquired war deafness will be amenable to surgery of any type other than that employed for correction of chronic infection.

"There is but one ready solution to this present and impending problem and that is the proper fitting of an adequate hearing aid," he said.

Subject: The Need for Protective Services in Time of War

Office of Civilian Defense
Washington 25, D. C.

To: Regional Medical, Nursing, Engineer, Gas and Rescue Officers.

From: Dr. George Baehr, Chief Medical Officer.

Rumors that civilian defense is no longer necessary have recently been spread by irresponsible persons. These rumors are thoughtless or calculatingly subversive, for they are not supported by Army authorities responsible for our coastal defenses nor by the present military situation.

Fortunately, the success of our armed forces overseas has saved us thus far from experiencing the horrors of enemy bombing to which the cities of our Allies are being subjected. In the opinion of the best military authorities our coastal areas and industrial centers will not be free of the danger of enemy attack from the air nor of widespread sabotage until the last day of the war.

Civilian defense is needed also as one of the essential measures for safeguarding internal security. This is especially true of the Emergency Medical Service. If we had not created a nation-wide organization for civilian defense two years ago, we would be obliged to organize one today for home security. Disasters of all kinds have increased because of the tremendous speeding up of our great industries, the overburdening of our railroads, and the inexperience of hundreds of thousand of new war workers. Our

police, our fire departments, our public works and utility services, and our hospitals, upon which we depend for protection, are being increasingly depleted of trained personnel.

We must, therefore, strengthen our voluntary protective services throughout the land. Along the Pacific and the Atlantic coasts, these services must be especially strong in volunteer personnel and equipment to guard us against the hazards of enemy attack and sabotage until that day when the Army, itself, advises us that the danger is ended.

Medical Journals—For Colleagues in Military Service

In former issues, editorial comment was made on a plan to forward medical journals to the Hospital Stations of Army, Navy, and Air Force camps now located in California.

This work is being carried on by the California Medical Association—through its Committee on Postgraduate Activities—in coöperation with the medical libraries of the University of California, Stanford, and the Los Angeles County Medical Association.

The addresses of the three libraries follow:

University of California Medical Library, The Medical Center, Third and Parnassus, San Francisco, California.

Lane Medical Library, Clay and Webster Streets, San Francisco, California.

Los Angeles County Medical Library Association, 634 South Westlake, Los Angeles, California.

If more convenient, you can send journals via "Railway Express Agency," collect, to: California Medical Association Postgraduate Committee, Room 2008, Four Fifty Sutter, San Francisco, California. Railway Express Agency addresses: In San Francisco, at 635 Folsom (EX 3100); in Los Angeles, at 357 Aliso (MU 0261). The "Railway Express Agency" will call for packages and will collect costs from the California Medical Association. The Postgraduate Committee will forward to camps.

Military Clippings.—Some news items of a military nature from the daily press follow:

Areas to Coöperate in Medical Service

Chiefs of the emergency medical service operating in connection with the Riverside County Defense Council recently decided to adopt the mutual aid plan outlined by state civilian defense officials.

Under this plan, equipment and personnel, if and when needed in any one area, will be supplied from other areas in a systematic and efficient manner.

Presiding were Roger Abbott, regional protection officer; and Dr. Charles Sebastian of Pasadena, southern sector medical officer.

Attending, in addition to Riverside County physicians, were Ralph Hughes, chairman of the Riverside County Defense Council; and Dr. Warren F. Fox, county health officer and emergency medical service coördinator.—Riverside *Enterprise*, October 1.

Army Doctors Attend Wartime Graduate Medical Meet Here

To keep doctors now in the Army informed about the latest progress in medicine, arrangements have been made to conduct wartime graduate medical meetings at some of the larger Army hospitals. Hammond General Hospital is among these.

Conducted by professors of the various medical schools, the meetings are operated by committees appointed by the American Medical Association and the American College of Surgeons.

The first of these meetings at Hammond Hospital was held last week. Approximately 150 doctors attended. These included the medical officers at Hammond, medical officers from other Army stations in California and Nevada, and members of the Stanislaus and San Joaquin County Medical Societies.

Technical lectures were given by Drs. Thomas Addis, Albert Davis and Alfred C. Reed of the Stanford University Medical School, Drs. William Kerr and H. Glenn Bell of the University of California Medical School, and Dr. Edmund Butler, chief of the San Francisco Emergency Services.—Modesto *Bee*, October 15.

Not Enough Physicians

Reports are that by the end of this year the United States will have about 53,000 doctors in military service to care for the 10,800,000 men in the Army, and that there will be 108,000 doctors left in this country to care for the nation's 120,800,000 civilians.

Since the doctors remaining in civilian practice are not distributed exactly in proportion to population, the doctor-to-population ratio in many war-congested localities exceeds the 1 to 3,000 figure regarded as needed to insure a fair standard of care.

The armed services must have proper medical attention; there will be no division of opinion about that. There is no escape from the probability that there will be an insufficient number of physicians for the civilian population until the end of the war. The question is how to make the best of an unsatisfactory situation, and one way in which all can join, is for every individual to take unusual care of his health in order to minimize the demands on the medical profession.—Long Beach *Press-Telegram*, October 10.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

Thirteenth Annual Midwinter Postgraduate Clinical Convention in Ophthalmology and Otolaryngology January 17 to 28, Inclusive, 1944

AUSPICES OF THE RESEARCH STUDY CLUB OF LOS ANGELES

* * *

Western Section meeting of the Triological Society, January 22 and 23. Members of the convention are cordially invited to attend.

Special course in "Applied Anatomy and Cadaver Surgery of the Head and Neck," January 28 to February 1, inclusive.

Examination of candidates by the American Board of Otolaryngology, February 2, 3, 4, and 5.

* * *

In certain parts of the country some well-meaning people have thought it best to discontinue scientific meetings on account of the war. The attitude of the Research Study Club is exactly the opposite. Whether the "protector" or the "protected"—and each of us is either the one or the other—total war means all of us. That side will win this war whose people are more wise, more alert, and more realistic. We are not defeated—nor do we intend to be. In this spirit, we will continue our postgraduate work throughout the duration—and after. By doing this we take our stand as a part of the great national plan to continue all wholesome activities as far as possible during this time of trouble.

This preliminary announcement gives the general outline of the courses. As soon as all final details are completed, we will issue the usual complete booklet program. Those desiring the final program will please write to The Research Study Club, 2509 West Washington Boulevard, Los Angeles.

This year New York City provides the two principal teachers—Isidore Friesner and James Watson White.

As all know, Doctor Friesner has always been an outstanding teacher. He will give the results of his rich experience through many years in the practice of Otolaryngology.

Lectures will also be given by members of the American Board of Otolaryngology, including Dr. Thomas E. Carmody, Denver; Dr. Frederick T. Hill, Waterville, Maine;

†Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

Dr. Dean M. Lierle, Iowa City; Dr. Carl H. McCaskey, Indianapolis; Dr. Arthur W. Proetz, St. Louis; Dr. Robert F. Ridpath, Philadelphia; Dr. Le Roy A. Schall, Boston; and Dr. John J. Shea, Memphis.

Dr. James Watson White of New York and Dr. Georgiana Dvorak Theobald of Oak Park, Illinois, will be the principal speakers on Ophthalmology. Irving B. Lueck, M. S., of Rochester, New York, whose lectures on prescription analysis have been so enthusiastically received, has been invited to participate again. Dr. Meyer Wiener will add to his already generous contributions on surgery of the eye.

At the suggestion of Doctor White, there will be made available to all who register for the Clinical Course copies of Duane's Thesis on Motor Anomalies of the Eye. Those desiring copies please enclose the sum of two dollars in addition to the registration fee.

Various other subjects pertaining to eye, ear, nose, and throat will also be given by representatives of the Medical and Technical Schools in Southern California.

As always, in deference to requests from the majority of those who have taken this course, the first week is devoted largely to the eye and the second week to the ear, nose and throat, so that those of us who confine our work to only one of these specialties can complete most of the subjects in only one week.

Many of those in all parts of our country and Canada possess motion pictures, specimens, plates, films and other treasures that can be shown for the benefit of all, and perhaps copies can be made of some of them to add to the library of our club. Everyone having something to show should write soon to Dr. Kenneth C. Brandenburg, 110 Pine Avenue, Long Beach, California, telling him the exact nature of the presentation and the length of time necessary, so that a definite place can be assigned on the program.

The fee for the Clinical Course is $50, one-half being due when you apply to take the course and the remainder upon registration. This is payable to Pierre Violé, M. D., 1930 Wilshire Boulevard, Los Angeles. It will be advisable to write at once for accommodations direct to H. M. Nickerson, Manager, Elks Club, Douglas MacArthur Park, Los Angeles, who will arrange to take care of as many as possible in the club itself. . . .

The special course in "Applied Anatomy and Cadaver Surgery of the Head and Neck" will be given again, directly after the Clinical Course. Dr. Simon Jesberg, whose gifts as a teacher and clinician we already know, will conduct this course in association with Dr. S. A. Crooks, Professor of Anatomy at Loma Linda College of Medical Evangelists. Doctor Crooks will demonstrate all anatomic relations in the different fields of head and neck surgery. As before, this course promises to be one of special practical value.

The Cadaver Course will begin at the conclusion of the Clinical Course (on January 28, 1944), and will carry into the following week—thus avoiding any conflict with the didactic lectures and the regular work of the clinical course. Twenty cadavers are available. This course is restricted to forty members—two to each table. The fee is $50. In order to register for this special course, kindly send $25 when registering for the Clinical Course and pay the other $25 at the opening of the course. Naturally, the members will be enrolled in the order of registration. In the future it may be possible to have a larger group, but this year only forty members can be provided for in the Cadaver Course.

The fee for the Clinical Course is $50. The fee for the Cadaver Course is $50. All those in active military service may enroll for the clinical course without the payment of a fee; and for the Cadaver Course for the payment of one-half of the regular fee—namely, $25.

Examination of candidates by the American Board of Otolaryngology will follow the Cadaver Course, on February 2, 3, 4 and 5. All prospective candidates should write immediately to Dean M. Lierle, M. D., Secretary of the Board, University Hospital, Iowa City, Iowa.

Years ago, when Col. Robert E. Wright came to us from India, the plans were made by a member of our club, Dr. Harry Gradle of Chicago. In Lund, Sweden, two of our members, Dr. Arthur Proetz of St. Louis and Dr. Howard House of Los Angeles, called on Dr. Gosta Dohlman and made all the arrangements for him to come to our course. No matter where he lives, each one who has enrolled is a member in good standing of the Research Study Club.

At long last, we are beginning to accumulate some money. This money belongs to you. Beginning in a modest way, we want to endow research work in various localities, publish results and send, without charge, monographs and books to each member. Please let us have your ideas.

THE COMMITTEE.

* * *

The Thirteenth Annual Midwinter Postgraduate Clinical Course in Ophthalmology and Otolaryngology of the Research Study Club of Los Angeles will be given from January 17 to January 28, inclusive, 1944. It will be followed immediately by the Special Course in Applied Anatomy and Cadaver Surgery of the Head and Neck.

The Club, always timely in its selection of topics and speakers, has been particularly fortunate in its selection of a faculty for 1944. Dr. James Watson White, of New York, and Dr. Georgiana Dvorak Theobald, of Oak Park, Illinois, will be the principal speakers on ophthalmology. Irving B. Lueck, M. S., of Bausch & Lomb, whose excellent lectures on Analysis of Presbyopic Prescription were heard last year, has been invited to participate again.

Doctor White plans to cover the motor anomalies of the eyes in a more comprehensive manner than is usually attempted in a short course. Sixteen hours of lectures will be given. Doctor White makes ingenious use of lantern slides projected upon a surface upon which he can draw with crayons to emphasize important points. In addition, there will be demonstrations by Doctor White and others of the use of the screen test, the screen comitance test and of loose prisms and other tests upon the results of which a sound diagnosis in motor anomalies must be founded.

Doctor White's name has become almost synonymous with motor anomalies in American ophthalmology. He has made this field especially his own and has been the teacher or guiding influence of most of the ophthalmologists who are doing the best work in this field today. His interest in the subject dates from 1913, and in March of 1914 he became associated with the late Alexander Duane. The association was so mutually agreeable that it persisted until Duane's death in 1926. Although Duane published his celebrated thesis, "A New Classification of the Motor Anomalies of the Eye, Based Upon Physiological Principles, Together with Their Symptoms, Diagnosis and Treatment," in 1896, the first edition of his translation of Fuchs's "Textbook of Ophthalmology" in 1892 and his well known chapter on the "Extraocular Muscles" in Poesy and Spiller's "The Eye and the Nervous System" in 1906, his work in the field of the motor anomalies would not be so well known today had it not been for Doctor White's continued interest in and teaching of the subject. The records of the American Board of Ophthalmology show that there is room for improvement in the teaching of this subject in most sections of the country. More candidates fail in motor anomalies than in any other subject, except pathology.

Doctor White is a talented teacher of long and varied experience. He was a clinical assistant at the Herman Knapp Memorial Hospital from 1914 to 1920 when he was appointed attending ophthalmologist and chief of the Vanderbilt Clinic, and consultant in ophthalmology to the Sloane Maternity Hospital.

Some years ago he resigned these positions to become professor of ophthalmology at the New York Postgraduate Medical School and Hospital. He is Director of the Ophthalmological Service and since 1930 has taught, personally, only motor anomalies.

His course in muscles at the Postgraduate School, which is given in the fall, is well known among ophthalmologists and at his Friday morning Muscle Clinics one may meet, for example, men from Florida, Canada and the West Coast, all in one day. His course in Los Angeles will contain substantially the same material that he uses in New York. The course is intensely practical and does not leave one with the vague feeling that one gets from a good deal that is taught and written on muscle anomalies, viz., that the subject is all, or nearly all, metaphysical.

A syllabus is in course of preparation which will enable the student to follow exactly the subjects under discussion and at the same time serve as a notebook.

Dr. Georgiana Dvorak Theobald became interested in eye pathology, as did so many others, from listening to the lectures delivered by the elder Fuchs when he came to America in 1922 and 1923. The simplicity and clarity of her demonstrations will strongly remind any one, who had the privilege of hearing him, of the great Fuchs. She is well known in the East and she needs no introduction to those who attended the midwinter course last year when she delivered one lecture on the general aspects of eye pathology.

COMMITTEE ON INDUSTRIAL PRACTICE

Big C. I. O. Health Conference in Los Angeles

On Sunday, September 19, the conference, "Health Joins the C. I. O.," will take place at the C. I. O. Building, 5851 Avalon Boulevard. The call to this all-day conference, asking for a minimum of four or five delegates from each local union and from all the shops in the Los Angeles area, states the purpose of this conference as follows:

"Health, or the lack of it, has long been a concern of union men and women. The war has only sharpened the need for labor participation in this field. Healthy workers mean uninterrupted production for victory. Inadequate health facilities and insufficient doctors in crowded war areas, a rising accident rate in industry and a deterioration of general community health must become key issues in a program for the unions."

"Can industrial health be improved through labor management committees on health? What kind of plans are available to provide medical care for workers and their families? What can be done about better health in the plants? What kind of health legislation do unions want?"

"These are the questions to which answers can be found only through a continuous program undertaken by labor itself. Discussion at the conference will contribute to set up such a program in an organized manner."

This, then, will be a working conference at which the delegates of the various unions will have a chance to set up a full-time health division within the C. I. O. Council, and to share in the planning of the program for such a division.

Noted Speakers

Leading national and local speakers have been secured who will discuss the various topics in the morning session, giving the delegates an opportunity to base their discussion during the afternoon panels on facts in health matters as they relate to the war effort and to a sound program for the years to come. Outstanding among the speakers will be Dr. Morris Raskin, Medical Coördinator of the Medical Research Institute of the N. A. W., and a pioneer in union health planning. His coming here has been made possible by the International of the N. A. W., who are paying Doctor Raskin's expenses. Doctor Raskin will discuss industrial health as it affects the workers, and how unions can help safeguard the health of their fellow workers. The topic of medical and hospital care will be discussed by Dr. Asher Gordon, resident physician at the Vallejo Housing Project and a member of California Physicians' Service, a prepayment group medical plan. Dr. Henry Borsook, Professor of the California Institute of Technology, and his coworker, Miss Nancy Upp. Field Director of the Los Angeles County and City Committee for Nutrition in Industry, will discuss how we can keep our workers at the highest level of efficiency through proper feeding methods in the plants.—San Pedro *Shipyard Worker.*

How Long Should a Man Work?

Somewhere there is a happy medium in the production period. If men work too long, they fatigue; and each task takes longer and longer until it is a losing battle. This, of course, does not even consider the poorer quality of work, the increased tendency toward accident or disease, and the steady rise in inefficiency.

On the other hand, if men do not work long enough, even though they do work efficiently, they cannot turn out the maximum number of units. There is man waste there—and again a losing battle. Somewhere between the two is the happy medium—the golden period where workers produce most without harming themselves or their product.

Now where is this period, important at any time in the smooth functioning of an industry, but especially important when a country is at war? A committee, representing the War and Navy Departments, the Maritime Commission, the Public Health Service, the War Manpower Commission, the War Production Board, and the Commerce and Labor Departments, studied the problem and here are its findings:

1. There should be a weekly day of rest. The Biblical injunction of one day's rest in seven seems to hold up after five thousand years. The seven-day work week for individuals is injurious to health, production, and morale. It slows down production because of the cumulative effects of fatigue when not broken by rest and relaxation. In fact, the workers take time off themselves. Too continuous work leads to increased absenteeism. Only in emergencies, and then for a limited time, should workers or supervisors (or doctors) forego their weekly day of rest.

2. There should be at least a thirty-minute meal period in midshift. Those working with toxic substances should be given sufficient time to cleanse their hands thoroughly before eating. (Physicians please note.) Also, there should be adequate food. Coffee and doughnuts for breakfast and a "coke" for lunch are not enough for a man or woman doing work.

3. The work-day should be eight hours long, and the week, six full days. Less than this makes for inadequate production. More than this, in time, results in impairing the health and efficiency of the workers and in decreasing the flow of production. Extra hours add little to output because the quality of work deteriorates not only during the extra hours, but also during the regular working hours; absenteeism rises sharply and accidents and illness increase.

4. There should be vacations completely away from the job. These vacations should be so staggered as not to delay production, and the period should be so balanced as to produce maximum benefit to the worker without too high a cost in productive hours lost.

Those are the recommendations, Doctor. How do they apply to your own practice and habits.—Norman R. Goldsmith, M. D., *Pittsburgh Medical Bulletin.*

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

MATERNITY-PEDIATRIC PLAN OF FEDERAL CHILDREN'S BUREAU

(Additional items—Continued from pages 79-88, CALIFORNIA AND WESTERN MEDICINE, for July (Items I to XVIII); September, pages 178-182 (Items XIX to XXIII); and October, pages 226-231 (Items XXIV to XXX).

* * *

ITEM XXXI: MATERNITY-PEDIATRIC

Important Letter from California Medical Association Council to California Medical Association Members

(COPY)

CALIFORNIA MEDICAL ASSOCIATION

San Francisco, October 22, 1943

The Members of the Component County Medical Societies of the California Medical Association, Addressed.

Subject: Maternity-Pediatric Program of the Federal Children's Bureau.

Dear Doctors:

This memorandum is sent to call attention to the action taken by the Council in regard to the Maternity-Pediatric program of the Federal Children's Bureau.

Following references are to special items in CALIFORNIA AND WESTERN MEDICINE, relating to actions taken by the California Medical Association:

July issue of CALIFORNIA AND WESTERN MEDICINE:

(*a*) Three hundred and eleventh Council meeting of June 19, 1943. Council resolutions appear under Item 7 on pages 72-73. (Appears also on page 81 as Item VI.)

(*b*) On page 83 is printed the letter of July 1, 1943, sent to the component county societies by Council Chairman Gilman. (Note: The second last paragraph was written in accord with the information at hand at that time.)

September issue of CALIFORNIA AND WESTERN MEDICINE:

(*c*) In the minutes of the 312th Council meeting, under Item 5(a) on page 171, the previous resolution was clarified by calling attention to a statement received from the California State Board of Public Health.

* * *

At the present time, the situation in California, in regard to maternity-pediatric work is as follows:

1. The California Medical Association has expressed approval of the objective to provide adequate maternal-pediatric care to the wives and infants of enlisted men.

2. The Council of the California Medical Association has *not* given approval to the regulations of the Federal Children's Bureau whereby the payments *must* be made to the attending physician.

3. Members of the California Medical Association are free agents in this work; each physician to decide for himself under what conditions he is willing to give the indicated professional services.

Since the physician has the privilege of deciding for himself whether he will or will not participate in the plan outlined by the Federal Children's Bureau, the following additional information is given:

(*a*) A physician is at liberty to sign Part II of the prospective mother's application (which she obtains from a local board of health, the same being a State Board of Health form), but in so doing the physician obligates himself to give the professional services stipulated for the money consideration also outlined. Further, the physician agrees that he will not accept additional compensation for the said services from the patient or patient's family. Provided, that services rendered prior to the day the prospective mother signed the application, or for services not stipulated in the prenatal, confinement and postpartum agreement, may be charged against the patient. (It is important that the physician read the agreement and inform himself concerning the services he will be called on to render, before he signs a prospective mother's application.)

(*b*) Members of the California Medical Association are also free to determine for themselves whether they will accept such patients as private patients, under agreements mutually agreeable between patient and physician; but in such cases, the physician must refrain from signing the agreement which the health boards give to prospective mothers who make request therefor.

However, if this latter course of a personal arrangement is followed, it is important to remember that the prospective mother will not be entitled to hospitalization or other benefits included in the Federal Children's Bureau program. (Note: This letter will be printed in CALIFORNIA AND WESTERN MEDICINE for November.)

If additional information is desired concerning the Federal Children's Bureau program, the physician should consult the health departments (preferably his local health department; or the California Bureau of Maternal and Child Health: 739 Phelan Building, 760 Market Street, San Francisco, 2, California; or, State Office Building, 217 West First Street, Los Angeles; or, 631 J Street, Sacramento).

Cordially yours,

KARL L. SCHAUPP, M. D., *President*

PHILIP K. GILMAN, M. D., *Council Chairman*

By GEORGE H. KRESS, M. D., *Secretary.*

ITEM XXXII: MATERNITY-PEDIATRIC

Maternity Care Funds Available

Resumption of the emergency maternity and infant care program (EMIC) is announced by Dr. Wilton L. Halverson, Director, California Department of Public Health.

Government-paid maternity care for wives of service men and medical care for their sick infants is available under the program which started in July and is now operating in thirty-five counties. Suspended on September 15, due to lack of funds, resumption is possible with telegraphic information from the United States Children's Bureau that funds are available immediately from a new congressional appropriation of $18,600,000.

The State Health Department has asked for an immediate grant of $461,606 to pay for the care of individuals whose applications already have been approved and to provide care through October, Doctor Halverson said.

High Medical Cost

"The United States Children's Bureau has been notified that, due to the large number of service men's wives living in California and the high cost of medical care here, it is estimated that $4,000,000 will be required to carry the program in this state through the 1943-44 fiscal year.

"Spread of the program to other counties in the state is awaiting completion of satisfactory arrangements with local health departments, physicians, and hospitals. Payment for care is made to doctors, hospitals, and private health agencies on a cost basis by health departments which administer the program."

Any woman, irrespective of her legal residence, whose husband is an enlisted man in the fourth, fifth, sixth, or seventh grades in the Army, Navy, Marine Corps, or Coast Guard, is eligible under the program for medical and hospital maternity care without cost to the family. Care is provided throughout pregnancy and for six weeks after delivery as well as at confinement. Any infant under one year whose father is a service man in these grades is entitled to care for serious illness.—Los Angeles *Citizen*, October 8.

ITEM XXXIII: MATERNITY–PEDIATRIC

Resolution Adopted by the San Francisco County Medical Society

The following resolutions were adopted at the meeting of the Board of Directors of the San Francisco County Medical Society held on October 5, 1943:

Resolved, That the San Francisco County Medical Society highly approves the plan of the Federal Childrens' Bureau to provide obstetric and pediatric care to the wives and children of the enlisted personnel of our armed forces. These people should have the best medical care that can be obtained, regardless of cost or their ability to pay; and be it further

Resolved, That the San Francisco County Medical Society believes that these people will not receive the best of medical care because they will not have free choice of physician and hospital, since only those physicians and hospitals who are willing to participate in this plan are available to them; and be it further

Resolved, That the San Francisco County Medical Society disapproves the undemocratic principle of any government agency establishing fees for services rendered by one individual to another.

ITEM XXXIV: MATERNITY–PEDIATRIC

Resolution Adopted by Placer-Nevada-Sierra County Medical Society

WHEREAS, The members of the Placer-Nevada-Sierra County Medical Society approve, in principle, the Federal Children's Bureau Plan for Maternity and Infant Care for wives and children of certain groups of enlisted men; and

WHEREAS, The members of the Placer-Nevada-Sierra County Medical Society agree, because of the present emergency, to coöperate in this plan for a limited period of time; and

WHEREAS, The members of the Placer-Nevada-Sierra County Medical Society are opposed to the type of contract proposed by the Federal Children's Bureau, particularly that part of the contract which specifies that the fee for obstetric care shall be paid directly to the Doctor; and

WHEREAS, The proposed scheme of medical care and hospitalization appears to be but the opening wedge for the introduction of socialized medicine; now, therefore, be it

Resolved, By the members of the Placer-Nevada-Sierra County Medical Society, at its meeting on September 5, 1943, that the said Society express its opposition to the proposed method of payment of fees; and be it further

Resolved, That the Secretary be instructed to petition the Council of the California Medical Association and the Board of Trustees of the American Medical Association that they make every effort to see that such changes are made in the Federal Children's Bureau Plan as to make the plan conform more closely to the ideals of organized medicine.

* * *

The foregoing Resolution, upon motion duly made, seconded and carried, was adopted by the Placer-Nevada-Sierra County Medical Society at a meeting held in Auburn on September 5, 1943.

ITEM XXXV: MATERNITY–PEDIATRIC

Resolution Adopted by the Riverside County Medical Association

At a regular meeting of the Riverside County Medical Association held on October 11, 1943, the plan of the Federal Children's Bureau Plan of Obstetrics and Pediatrics care for wives and children of enlisted men in the armed forces was discussed and a motion was made and carried, a copy of which is as follows, for your consideration.

"Moved and seconded that this Association go on record that no member of the Riverside County Medical Association sign any slip which entitles the doctor to accept any fee for the care of these cases from the Government. Carried."

It should be added here that this Association does not oppose hospitalization of these patients through Federal funds. Furthermore, our members have expressed their willingness to care for these patients according to any financial arrangement that may be agreed upon between the doctor and the patient.

In effect, the members of the Riverside County Medical Association will continue to carry on the practice of medicine in accordance with the sentiment expressed above until at such time the Council of the California Medical Association may offer a final solution, and we urge the Council to take a definite stand and we also urge other county associations to take similar action.

We wish to state that we are willing to abide by the decision of the Council of the California Medical Association.

October 19, 1942.

ITEM XXXVI: MATERNITY–PEDIATRIC

Resolution Adopted by the Los Angeles Obstetrical and Gynecological Society

WHEREAS, Congress has enacted a grant-in-aid law designed to provide maternity-pediatric care for the wives and infants of enlisted men, an objective with which members of the medical profession are in full accord; but

WHEREAS, The Federal Children's Bureau of the Department of Labor, to which agency the administration of the law has been given, has seen fit to lay down rules and regulations which will undoubtedly make for maternity-pediatric care of poorer quality than is now rendered by physicians, thus defeating in part the primary purpose of the law; and

WHEREAS, The arbitrary establishment by the Federal Children's Bureau of below cost fee schedules for the professional services to be rendered not only makes for professional service of poor quality, and at the same time penalizes the medical profession whose members gratuitously and gladly give to the Government professional services in the examinations of selectees under the Selective Service Act which, if translated into money, would amount to millions of dollars; and

WHEREAS, In war industries a cost plus instead of a cost minus system is in full operation for citizen groups who have given no such massive contribution to the Government as have members of the medical profession; and

WHEREAS, The evils in the system that has been formulated by the Children's Bureau could be done away with in good part, if the grant-in-aid payments were made, not to the attending physician direct, but to the wives of the enlisted men, the patients to make their own financial arrangements with their attending physicians; be it

Resolved, By the Council of the Los Angeles Obstetrical and Gynecological Society, a group of more than one hundred specialists in obstetrics working in Southern California, a majority of whom have been certified by the American Board of Obstetrics and Gynecology that, on behalf of its members, full approval of the objective of adequate maternity-pediatric care for the wives and infants of enlisted men is given; and be it further

Resolved, That it is the opinion of this body that the best professional and other interests of the wives and infants of enlisted men would be served if the law of the Federal Children's Bureau plan would be changed to permit the grant-in-aid payments to be made direct to the

wives of enlisted men instead of to the attending physicians; and be it further

Resolved, By the Council of the Los Angeles Obstetrical and Gynecological Society that the Councils of the California Medical Association and the Los Angeles County Medical Association be informed that the members of the Los Angeles Obstetrical and Gynecological Society prefer to render these professional services without pay to the wives of enlisted men who are deserving rather than accept the fee schedule, contract, and other procedures of the Federal Children's Aid Bureau; and

Resolved, That the Council of the California Medical Association be requested to take promptly all necessary steps, by letter if necessary, in addition to what may appear in the OFFICIAL JOURNAL to inform all members of the California Medical Association concerning the procedures to be preferably followed in relation to this maternity-pediatric work in this State; and

Resolved, That copies of this resolution be sent to the following:

The United States Senators and Congressmen from California. The officials in the United States Department of Labor and Children's Bureau who have charge of the administration of the Act; the California State Board of Public Health members; the officers of the American Medical Association (trustees, secretary, and editor); the secretaries, and editors of the State Medical Associations; the Obstetrical Societies in the different States of the Union; the Pacific Coast Obstetrical and Gynecological Society; and the American Board of Obstetrics and Gynecology.*

WAGNER-MURRAY-DINGELL BILL
(S. 1161; H. R. 2861)
Resolution Adopted by the American Bar Association

The following resolution, presented to the American Bar Association by Loyd Wright, Los Angeles attorney, was adopted by that Association:

Resolved, That the Board of Governors be requested to immediately appoint a special committee to study, analyze and investigate Senate Bill 1161 and that the Board of Governors give publicity to the recommendations and findings of such special committee and the action of the Board of Governors taken thereon; be it further

Resolved, That the House of Delegates is opposed to any legislation, decree or mandate that subjects the practice of medicine to federal control or regimentation beyond that presently imposed under the American system of free enterprise.

Wagner-Murray-Dingell Bill—"Cradle to Grave" Measure (S. 1161; H. R. 2861)

The analysis of features of the Wagner Bill (S. 1161; H. R. 2861) which follows has been printed by the California Public Health League. It is here presented for its informative items:

(COPY)

And Now It Is a Sickness Tax!

The medical bills of 110,000,000 people will be placed on the shoulders of the taxpayers under provisions of the Wagner Bill (Senate Bill 1161) now pending in Congress.

This scheme to socialize medical, dental, hospital and nursing care was introduced in the United States Senate on June 3, 1943, by Senator Robert F. Wagner of New York—for himself and Senator James Murray of Montana. It would broaden the Social Security Act by—

1. Imposing a tax of 6 per cent on the wages of all persons earning up to $3,000 per year. This is in addition to the present 20 per cent income tax and many other deductions from the weekly or monthly pay check.

2. Imposing a similar tax of 6 per cent on the employers.

3. Imposing a tax of 7 per cent upon self-employed individuals on the market value of their services up to $3,000 per year.

A TOTAL TAX OF $12,000,000,000 (TWELVE BILLION DOLLARS ANNUALLY).

A Federal Bureau Will Control All Health Services!

This scheme to socialize medical, dental, hospital and nursing care would be under complete control of the Surgeon-General of the Public Health Service.

The Surgeon-General would have power and authority to—

1. Hire physicians and establish rates of pay—possibly for all physicians.
2. Establish fee schedules for services.
3. Establish qualifications for specialists.
4. Determine the number of individuals for whom any physician may provide service.
5. Determine arbitrarily what hospitals or clinics may provide service for patients.
6. *Arbitrarily assign you to a physician, if you fail to select one of your own choice.*

Dental and Nursing Service

Section 912 of the Bill provides: "The Surgeon-General and the Social Security Board jointly shall have the duty of studying and making recommendations as to *the most effective methods of providing dental, nursing, and other needed benefits not already provided under this title.*"

The Surgeon-General is to find a way to provide dental and nursing care.

"A Menace to Medicine"

(Here is what the San Francisco *Call-Bulletin* says about this scheme in its editorial columns of August 10, 1943):

"Hidden among the provisions of the Wagner-Murray bill to broaden the Social Security Act, which now is pending before the Senate, is one which effectually would destroy the free practice of medicine in the United States.

"It would accomplish this by placing the entire medical profession, including its schools, hospitals, and clinics, under the direct or indirect control of the Surgeon-General of the Public Health Service, and by adding to the burden of the taxpayers the medical bills of some 110,000,000 people.

"Under the system of socialized medicine which the Act would set up, the citizen would be deprived of his privilege of seeking treatment from a physician of his choice or at a hospital or other institution of his choice, and would be required to seek service from the doctor and institution indicated by the health service.

"The goal at which the bill is directed—adequate medical service for all—is most commendable, and is one toward which the free medical profession long has been striving and hopes soon to reach.

"But the socialistic approach of the Wagner-Murray bill is vicious, and every citizen should join with the medical profession in urging that the measure be rejected."

It Is Up to You

Do you want this tax saddled onto you? Do you want your health services regimented under a Washington Bureau?

Tell your Senators and Congressman!

California in Congress

Senators should be addressed in care of the Senate Office Building, and Congressmen in care of the House Office Building, Washington, D. C.

---

* For Resolution XXXVII: Maternity–Pediatric program (Resolution of five Pacific states), see page 293.

Following is the roster from California with home addresses:

SENATORS:

Hiram W. Johnson, Mills Tower, San Francisco.
Sheridan Downey, Atherton.

CONGRESSMEN:

First District: Clarence R. Lea, 719 North Street, Santa Rosa.
Second District: Clair Engle.
Third District: J. Leroy Johnson, 1621 Argonne Drive, Stockton.
Fourth District: Thomas Rolph, 152 Twenty-eighth Avenue, San Francisco.
Fifth District: Richard J. Welch, 978 Guerrero Street, San Francisco.
Sixth District: Albert E. Carter, 552 Montclair Avenue, Oakland.
Seventh District: John H. Tolan, 1749 Pleasant Valley Avenue, Oakland.
Eighth District: John Z. Anderson, San Juan Bautista.
Ninth District: Bertrand W. Gearhart, 857 M Street, Fresno.
Tenth District: A. J. Elliott, P. O. Box 134, Tulare.
Eleventh District: George E. Outland, 539 East Micheltorena Street, Santa Barbara.
Twelfth District: H. Jerry Voorhis, R. F. D. 1, San Dimas.
Thirteenth District: Norris Poulson, 317 South Commonwealth, Los Angeles.
Fourteenth District: Thomas F. Ford, 940 North Benton Way, Los Angeles.
Fifteenth District: John M. Costello, 5771 Valley Oak Drive, Hollywood.
Sixteenth District: Will Rogers, Jr., 14253 Sunset Boulevard, Los Angeles.
Seventeenth District: Cecil R. King, 1152 West Eighty-eighth Street, Los Angeles.
Eighteenth District: Ward Johnson, 790 Santiago Avenue, Long Beach.
Nineteenth District: Chet Holifield, 500 South Montebello Boulevard, Montebello.
Twentieth District: Carl Hinshaw, 3053 Lombardy Road, Pasadena.
Twenty-first District: Harry R. Sheppard, Yucaipa.
Twenty-second District: John Phillips, 65 North Fourth Street, Banning.
Twenty-third District: Ed V. Izac, 5380 El Cajon Boulevard, San Diego.

Why Be "Copy Cats"?

The argument has been advanced that if one believes in a free public school system, one should not object to "free medicine" controlled and paid for by the State.

There is considerable difference between a public school system to give every individual a chance for mental equipment with which to earn a living and care for himself, and furnishing the individual, at State expense, the various necessities and luxuries of life.

"Cradle to the grave" security sounds appealing, but a nation which accepts that plan sells its independence and admits that its people cannot care for themselves.

The American medical system has been the wonder of this war. It was not developed or fostered by the State. It was the result of enterprise and initiative of American doctors who over a long period of years have been determined to make American medicine supreme.

American medicine probably gives more actual free service to those who need it than do the so-called socialized medical systems of foreign countries, which load the cost of their "free" service onto the individual in the form of special taxes.

Why should we in this country even consider disrupting the greatest medical system in the world to copy experiments of nations which cannot match ours in medical progress?

The Wagner-Murray bill now pending in Congress would regiment American doctors. This vicious measure should and must be defeated.—Editorial in the San Francisco *Commercial News,* October 18.

"Federal Medicine"

When Congress gets around to debating the new Social Security Bill, one item likely to encounter particularly heavy weather is the section entitled "Federal Medical Hospitalization and Related Benefits." This section provides for a federalized system of hospitalization and outside medical care which would be financed by a tax of 3 per cent on all wages and salaries up to $3,000 a year—one-quarter of the total Social Security tax. The proceeds of this tax will, of course, vary with conditions in industry. The income available for medical care has been estimated as high as $3,000,000,000 a year. Make it $2,000,000,000, and the Government could still hire every doctor in the United States at $5,000 a year, rent every bed in all non-Government hospitals, and have a goodly sum left over for subsidized research, administration, and other uses certain to occur to the gigantic bureaucracy which would have to be set up (*The Saturday Evening Post*).—San Francisco *Underwriters' Report,* October 14.

"Sheep Dip": Or Social Security Service and the Doctors

We are in receipt of a circular and booklet issued by the National Physicians' Committee for the Extension of Medical Service, apparently the first blast of the medicos and dentists against the "cradle to the grave" Social Security service.

It is to be deplored if this contest is to be regarded as one between the Government and the doctors. Those of us who furnish the blood and guts ought to have something to say, and what we say should be aplenty.

If the Government has to regiment us in some way and there is no escape, we wish it would commence somewhere else. There is such an intimate connection between us and our appendix that we would like to have the association disturbed only by our friends if segregation there must be.

When it comes to going under the ether and not being able to boss the job, our strong preference would be to have the incisions and perforations made by someone who has a personal or at least a professional interest in the case and who would feel deep chagrin should he omit to replace some of the reconditioned parts. Better yet, if our relations are such that we call him Jim and he calls us Pete. We don't crave to be checked in and checked out under a Social Security number or an auto license.

There isn't anybody we need so much as a doctor when we want a doctor, and there isn't any kind of doctor we want so much as one who will exert all the skill and science he possesses for which he expects and deserves to be paid promptly and well. A hospital is no place to hunt bargains.

Doctor Holmes said that if all the medicine were dumped into the sea it would be so much the better for men and so much the worse for the fish. If we are going to experiment, let us try that. The idea of being run through a physician's office like sheep through a trough of sheep dip does not appeal. We cannot expect much professional anxiety or interest for 75 cents. If that is all we have to spend, better to stay away from the doctor, whoever he is. We may recover anyhow.

Mixing politics with medicine or dentistry is like breaking an antique egg into an omelet; it spoils the dish. Imagine an ogre of a dentist bearing down on you and saying, "Now this is going to hurt—unless you vote for Doctor Geevum."—Riverside *Press.*

Group Medicine Progress Along American Lines Threatened by Bureaucratic Proposal

Few will disagree that the history of medicine in the United States is a consistent record of expanded service, scientific advance and social responsibility. We need only

to look around us in this community to realize how thoroughly well our medical men and our officials responsible for community health have risen to their social responsibilities. The very best in medical care and hospital services and facilities have been provided, much at public expense. The burden of unforeseen emergency costs has been lightened by hospitalization insurance plans that do not destroy individual self-respect. The same is generally true throughout the nation. There is, of course, much yet to be done, but coöperative common sense is making progress in the American way without sacrificing the important personal relation between patient and physician and without relieving the patient of his own responsibility in providing, to the extent that he is able, for his own medical needs through participation in "group medicine" insurance plans built up by individual initiative and without arbitrary Government procedure.

One of these "protection in advance" groups, and there are many others, is the Blue Cross plan. This single plan already protects some 15,000,000 Americans against emergency hospital expense. The progress being made is real and built on sound American tradition.

Now this good work, this healthy progress which flows out of the best American traditions and engages the self-help impulses and love of independence so characteristic of Americans, faces the blight of Government competition of the bureaucratic variety.

A new Social Security bill is before Congress. In this bill is a section entitled "Federal Medical Hospitalization and Related Benefits." This section would be financed by a tax of 3 per cent on all wages and salaries up to $3,000 a year. Its proceeds would vary, naturally, with conditions in industry. The tax is one-quarter of the total Social Security tax and has been estimated to bring in as high as three billion dollars a year which, as the *Saturday Evening Post* reminds us, would give the bureaucrats of this vast scheme of state medicine as much money to spend as was considered sufficient to run the whole country some short fifteen years ago.

In view of the progress of group medicine, with its protection of professional standards, local administration and community responsibility, the whole grandiose scheme of centralized and arbitrary state medicine seems not only uncalled for, but enormously wasteful and dangerous. It is to be hoped that the medical profession, with its fine record of social service and often selfless devotion to human needs, will rally in opposition to this gigantic Santa Claus dream. The good and increasingly successful efforts of American medicine to meet the country's health needs deserve protection from the half-baked designs of political bureaucrats.—Oakland *Tribune*, October 2.

The British Medical Association and the Beveridge Scheme

The stand made by the representatives of the British Medical Association against the Government proposals has been described in a previous letter (J. A. M. A., July 10, p. 759). The discussions with the Minister of Health are concluded and the next stage is the issue by him of what is called "a white paper" surveying the position. The representatives of the Association urged on him that this paper should be confined to a statement of the problems and not commit the Government to any solution, thus facilitating frank discussion by the public and the profession. On the Minister's ruling, the discussions were confined to a consideration of a comprehensive health service available to the whole community. They ranged over a wide field, such as central and local administration, health centers, free choice of doctor, private practice, and remuneration.

The Council of the British Medical Association has reaffirmed certain basic principles laid down in the Association's "General Medical Service for the Nation," approved in 1938:

1. The system should be directed to the achievement of health and prevention of disease no less than to the relief of sickness.

2. There should be provided for everyone a family doctor of his own choice.

3. Consultants and specialists, laboratory and other auxiliary services, institutional provision when required, should be available through the agency of the family doctor.

These recommendations and the following further ones are submitted by the Council for consideration by the divisions of the Association:

The state should not assume control of doctors rendering personal service. It is not in the public interest to convert the medical profession into a salaried branch of government service.

Free choice of doctor should be preserved and the state should not invade the doctor-patient relationship. Free choice of doctor should be reinforced by a method of remuneration related to the amount of work done.

Consultants and specialists should normally be based on the hospital. For those who wish to be treated in private accommodation, whether part of a hospital or not, private consulting practice should continue as at present.

The central administrative body set-up for the medical service of the future should be responsible for all civilian health services. The minister to whom this body is responsible should be advised on medical matters, including personnel, by a medical advisory committee representative of the medical profession.

Locally, new administrative bodies, responsible to the central authority, should cover wide areas and should be representative of the community served and, in appropriate numbers of the local profession and voluntary hospitals.—From "Foreign Letters," in *The Journal of the American Medical Association.*

Health Peril Shown in Social Medicine Plan

Congressman Says Scheme Would Curb Research and Initiative

Washington, Oct. 1.—Vast numbers of American people may be sentenced to an early death if the radical planners pervading the Government shackle the medical profession in their scheme for State Socialism, Representative Joseph W. Martin, Jr., of Massachusetts, House minority leader, warned tonight.

Representative Martin issued a ringing denunciation of bureaucracy, and of the trend toward the destruction of the American form of government in an address before the Medical Society of the District of Columbia. He charged:

"For some years a small but powerful group in this country has endeavored to undermine American institutions, American ideals, and our American way of life. I do not believe it is an exaggeration to say that they are represented in every department of our Government.

The minority leader spoke at length on the dangers that State Socialism presents in the field of medicine. But he warned that what was true of medicine might be true of every other field of American life.

In the field of medicine, Martin said, physicians and researchers have materially increased the health and the life span of the average man and woman of the past. He said:

"You have been able to accomplish this because your profession has been free.

"It has been free to dare. It has been free to progress."—David Camelon, in the San Francisco *Examiner*, October 2.

RE: MIGRATORY AGRICULTURAL WORKERS: THEIR HEALTH CARE

Amendment to Public Law 45

(COPY)

CALIFORNIA MEDICAL ASSOCIATION

San Francisco, October 21, 1943.

The Officers of the Component County Medical Societies of the California Medical Association,
Addressed.

Dear Doctors:

This memorandum is sent to call your attention to a letter dated October 18, 1943, which was sent to the U. S. Senators and Congressmen from California, and to Senator Claude Pepper of Florida. (A copy of the letter is enclosed.)

It calls attention to the need of amending "Public Law 45, Section 3 (a) (2)" so that agricultural workers who have secured work in agricultural pursuits through agencies other than the "Government Employment" Departments, would not be deprived of indicated medical care.

* * *

You may wish to send an air mail letter or telegram to the California Senators and the Congressman from your district, asking them to support the proposed amendment to the Public Law noted above. (The list of Congressmen is given on page 85 of the July, 1943, issue of CALIFORNIA AND WESTERN MEDICINE.*)

For such coöperation as you may be able to give, accept our thanks.

Cordially yours,

KARL L. SCHAUPP, *President.*
By GEORGE H. KRESS, *Secretary.*

* * *

(COPY)

CALIFORNIA MEDICAL ASSOCIATION

San Francisco, October 18, 1943.

The Honorable Hiram W. Johnson
U. S. Senator from California
Senate Office Building
Washington, D. C.

Dear Senator Johnson:

This letter is written on behalf of the agricultural workers of California who have been served by the Agricultural Workers Health and Medical Association in the past. Our attention has been directed to the present situation by the medical members of their Board of Directors.

Your attention is called to that section of Public Law 45 regarding the migratory agricultural workers and their families who would be eligible for health and medical service.

The present wording of the Act is so restrictive that it excludes from medical care all agricultural workers who do no receive their employment as a result of some activity of some of the Government agencies financed by Public Law 45. This means that our own American agricultural workers who have sufficient initiative and ingenuity to develop employment resources of their own are denied medical assistance.

In order to broaden the scope of professional services to be rendered, a proposed amendment to Public Law 45, Section 3 (a) (2) has been suggested. The proposed amendment would be as follows, the amendments being in italics:

Section 3 (a) (2) furnishing, by loans or otherwise, of health and medical and burial services, training, subsistence, allowances, protection, and shelter for such workers and their families; *provided, further, that funds available to the Administrator may be used for providing health and medical services to other migratory workers and their families who have entered the area without recruitment or assistance of any Government agency and have engaged in agricultural work and to whom adequate health and medical services are not otherwise available in the area where they are working.*

* * *

The California Medical Association, an organization of some 7,000 licensed physicians and surgeons, through the Council, its constituted authority, requests your support of the proposed amendment.

May we express the hope that you will write us in regard thereto? Kindly address your communication to Karl L. Schaupp, M. D., President, California Medical Association, 450 Sutter Street, Room 2004, San Francisco, 8, California.

With thanks for your help in this,

Cordially yours,

THE COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION.
Karl L. Schaupp, M. D., *President.*
Philip K. Gilman, M. D., *Chairman.*
(Signed) George H. Kress, M. D., *Secretary.*

(REPLY)

UNITED STATES SENATE
COMMITTEE ON FOREIGN RELATIONS

November 2, 1943.

Karl L. Schaupp, M. D., President
The Council of the California
Medical Association
San Francisco 8, California

Dear Doctor Schaupp:

In response to your letter of October 18, I send you herein copy of bill introduced by me covering the amendment proposed in your letter. I will do what I can to secure the early consideration of this amendment.

Sincerely yours,

[Enc.] (Signed) HIRAM W. JOHNSON.

* * *

(COPY)

UNITED STATES SENATE
COMMITTEE ON FOREIGN RELATIONS

Thursday, October 28.

Senator Johnson: The California Medical Association asks this amendment:

The story is this: They say the present wording of Public Law 45, providing medical care for migratory agricultural workers, is so restrictive that it excludes from medical care all agricultural workers who do not receive their employment as a result of some Government activity; which means that our own American agricultural workers who have sufficient initiative to develop some employment resources of their own are denied medical assistance.

* * *

78th Congress
1st Session

S. 1493

A BILL

To amend section 3(a) of the joint resolution entitled "Joint resolution making an appropriation to assist in providing a supply and distribution of farm labor for the calendar year 1943," approved April 29, 1943, as amended.

By Mr. Johnson of California

OCTOBER 29 (legislative day, October 25), 1943

Read twice and referred to the Committee on Appropriations

* In this issue the roster of California Congressmen appears on page 285.

78th Congress
1st Session

S. 1493

IN THE SENATE OF THE UNITED STATES

October 29 (legislative day, October 25), 1943

Mr. Johnson of California introduced the following bill, which was read twice and referred to the Committee on Appropriations.

A BILL

To amend section 3(a) of the joint resolution, entitled "Joint resolution making an appropriation to assist in providing a supply and distribution of farm labor for the calendar year 1943," approved April 29, 1943, as amended.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That subsection (a) of section 3 of the joint resolution, entitled "Joint resolution making an appropriation to assist in providing a supply and distribution of farm labor for the calendar year 1943," approved April 29, 1943, as amended, is amended by striking out the word "and" before the figure "(5)" in the last sentence in such subsection; and by striking out the period at the end of such sentence and inserting in lieu thereof a semicolon and the following: "and (6) furnishing, by loans or otherwise, of health and medical services to migratory workers engaged in agricultural work, and to members of the families of such workers, to whom adequate health and medical services are not otherwise available in the area where they are employed, whether or not such workers have been recruited or transported pursuant to this joint resolution."

* * *

Editor's note.—It is planned to have a companion bill submitted to the House of Representatives. Comment thereon will appear in the December issue of CALIFORNIA AND WESTERN MEDICINE.

Some Replies from Congressmen: Re Agricultural Workers' Program

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D. C.

October 22, 1943.

Dear Doctor Schaupp:

This will acknowledge a letter from Doctor Kress dated October 18, with reference to Public Law 45.

In reply, I should like to advise that I am in sympathy with the point of view brought out in the communication referred to and believe I can assure you of my favorable consideration when the matter comes before the House of Representatives for further action.

Trusting my attitude meets with your approval, and with best wishes to yourself and members of your organization, I am

Sincerely yours,

(Signed) JOHN Z. ANDERSON.

[Member of Congress, 8th District, California.]

* * *

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D. C.

October 25, 1943.

My dear Doctor Schaupp:

I am very much in favor of an extension of health and medical services financed by the Federal Government, and if an amendment to Public Law 45 is the best and most feasible way of bringing this about in relation to American agricultural workers I shall be glad to give it my support.

As you know, Public Law 45 makes an appropriation to provide a supply of farm labor only for the calendar year 1943. The question will undoubtedly come before the House again, and this would give an opportunity for offering amendments.

Sincerely yours,

(Signed) GEORGE E. OUTLAND.

[Member of Congress, 11th District, California.]

* * *

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D. C.

October 22, 1943.

George H. Kress, M. D., Secretary
California Medical Association

Dear Sir:

Your letter of the 18th, wherein you suggest an amendment to Public Law 45, Section 3 (a) (2), noted.

An amendment of this character should, in my opinion, be taken up with your National organization and have its Washington representative call upon the Legislative Committees of the House and Senate handling legislation of this character and route it through these two committees and then you will have a chance of amending the Act.

I will be very pleased to coöperate with your representative if he can find the time to call at my office on the subject.

Yours truly,

(Signed) HARRY R. SHEPPARD.

[Member of Congress, 19th District, California.]

* * *

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D. C.

October 23, 1943.

Dear Doctor Schaupp:

I am very glad to have your letter of October 18 regarding amendment to Public Law 45. I certainly feel that the migratory workers and their families are entitled to every possible health benefit, and will be glad to follow the recommendations of your organization.

Sincerely,

(Signed) BILL ROGERS.

[Member of Congress, 16th District, California.]

* * *

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D. C.

October 22, 1943.

Dr. George H. Kress, Secretary
The Council of the California Medical Association

Dear Doctor Kress:

I wish to acknowledge your letter of October 18 written in behalf of the agricultural workers of California. Congressman John Phillips, former State Senator, is a member from California on the Agricultural Committee of the House, and I am turning over your letter to him, because he is in a better position to give you this information than I am.

With all good wishes, I am

Sincerely yours,

(Signed) NORRIS POULSON.

[Member of Congress, 13th District, California.]

UNITED STATES SENATE
COMMITTEE ON MILITARY AFFAIRS

October 23, 1943.

Karl L. Schaupp, M. D., President
California Medical Association

Dear Doctor Schaupp:

Thank you for your letter of October 18, and you may be assured I shall be glad to support the proposed amendment to Public Law 45, Section 3 (a) (2) which has been suggested.

I would welcome hearing further from you of any action you may wish me to take in this matter.

Sincerely,

(Signed) SHERIDAN DOWNEY.
[Member of United States Senate.]

* * *

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D. C.

October 22, 1943.

Dr. Karl L. Schaupp, President
California Medical Profession

My dear Doctor Schaupp:

Receipt is acknowledged of Doctor Kress' letter of October 18, quoting proposed amendment to Public Law 45 covering agricultural workers.

I presume this proposed amendment has been submitted to the Chairman of the House Committee on Appropriations, from which Committee the original law was reported. I shall be very glad to give this bill my own personal consideration if and when it comes before the House for action.

Very sincerely yours,

(Signed) RICHARD J. WELCH.
[Member of Congress, 5th District, California.]

* * *

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D. C.

Dear Doctor Schaupp:

This will acknowledge receipt of your letter of October 18, suggesting a revision of Public Law 45.

This appears to me to be a very reasonable proposal, and I assure you the matter will receive my careful consideration.

Sincerely yours,

(Signed) LEROY JOHNSON.
[Member of Congress, 3d District, California.]

* * *

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D. C.

October 22, 1943.

Dear Doctor Kress:

Agricultural Workers' Health and Medical Association

Your letter of October 18 received, and I shall be pleased to investigate the possibility of amending Public Law 45 as suggested.

As soon as I have further information I shall let you know.

In the meantime, assuring you of my desire to be of service constantly, I am

Cordially,

(Signed) THOMAS ROLPH.
[Member of Congress, 4th District, California.]

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D. C.

October 26, 1943.

Dear Doctor Kress:

Thank you for your letter of October 19 about the importance of adding an amendment to Public Law 45 so as to make it possible for the California Medical Association to carry on the excellent work that has been done among agricultural workers in recent years.

I certainly do not see any reason why there should be discrimination in favor of people especially brought in from Mexico over our own people who have been here for a long time.

Sincerely yours,

(Signed) JERRY VOORHIS.
[Member of Congress, 12th District, California.]

* * *

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D. C.

October 27, 1943.

Karl L. Schaupp, M. D., President
California Medical Association

Dear Doctor Schaupp:

The letter of October 18, 1943, from your secretary in regard to a proposed amendment to Public Law 45, Section 3 (a) (2) has been received and carefully noted. The proposed amendment appears to me to have merit and I can see no reason for not giving it my support. It would appear that the classifications in the law should not be discriminatory, but should cover all persons within a general classification.

Very sincerely yours,

(Signed) CLAIR ENGLE.
[Member of Congress, 2nd District, California.]

(COPY)

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D. C.

October 29, 1943.

Dr. George H. Kress, Secretary
The Council of the California
Medical Association

Dear Doctor Kress:

Referring to your letter of the 18th, regarding the proposed amendment to Public Law 45, Section 3 (a) (2), may I say that I think this is a very meritorious amendment and I will support the same.

With all good wishes, I am

Sincerely yours,

(Signed) JOHN H. TOLAN,
[Member of Congress, 7th District of California.]

Orthostatic Albuminuria.—Before a diagnosis of orthostatic albuminuria is made, the following criteria should be met: (1) No past history of renal disease; (2) normal blood chemistry, nonprotein nitrogen, blood urea, total protein and albumin-globulin ration; (3) normal kidney function (phthalein, urea clearance, and dilution and concentration tests); (4) no white blood cells, red blood cells or casts in the urine, except intermittently and in small numbers; (5) no elevation of blood pressure; (6) negative plain x-ray pictures and intravenous urograms; (7) absence of albumin in the urine voided when in the recumbent position.—H. H. Young et al., Baltimore, in *Military Surgeon,* April.

COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

San Francisco Hospitals Accept the Nurses' Association Plan

San Francisco's registered nurses, their forces vastly decreased because of wartime demands, have developed a plan to give the maximum of nursing service to the greatest number of hospital patients.

The plan, to go into effect in twelve of the city's thirteen hospitals on Monday, was presented to and accepted by hospital administrators yesterday.

Under the plan, prepared by the San Francisco County Nurses' Association, private duty nurses will be called to do staff replacement on a basis of alphabetical sequence, working straight eight-hour shifts as often as needed.

Hospital administrators have agreed to use the part-time services of those private duty nurses who are unable to function on a full-time basis. They also have agreed to stimulate the use of divisional nursing and, in turn, the city's nurses have agreed to sign for at least three hospitals for periods of staff replacements.

Objectives

Objectives of the staff replacement plan are to supplement the nursing service so that the staff nurse may be protected from too heavy a case load; to assure the hospital and the community of the earnest desire of private duty nurses to make their contribution to the maintenance of essential hospital service during this period of war emergency; to insure the existence of the private duty nursing system and, finally, to assure the maintenance of a form of employment for registered nurses who are unable to engage in full-time general staff nursing. . . .—San Francisco *Chronicle*, October 27.

Nursing Plan to Be Tried for Three Months*

Stanford Hospital yesterday accepted, on three months' trial, the County Nurses' Association plan under which private duty nurses will be routed through tours of duty as general nurses in all San Francisco hospitals.

Following a meeting of the governing committee of the hospital, Dr. Anthony J. J. Rourke made public a letter addressed to the private nurses at Stanford, who protested the hospital's plan to discontinue private nursing, transferring private nurses to general duty.

The letter informed the private nurses that action on the "Stanford" plan will be postponed until February 1, 1941, to give a *"fair trial"* to the nurses' proposal.

It was announced Tuesday that the twelve other hospitals in the city had agreed to the Nurses' Association proposal which is aimed at supplementing nursing service in all hospitals to relieve the pressure on general duty nurses.—San Francisco *Examiner*, October 28.

Nurses Needed by the Army

The number of nurses required by the Army is in direct ratio to its numerical strength, based on exhaustive studies of actual bed requirements for battle casualties in former wars, and the health reports for the Army as a whole over a period of years. One nurse to each ten beds is authorized, but this number provides for all assignments, such as administrative, supervisory, teaching and professional, where bed credits do not exist, such as hospital trains and ships, air evacuation units and general dispensaries. Our present strength is 3,000 below our quota. Nevertheless, up to this time we have been able to meet our needs for two reasons:

1. We have had an unusually low incidence of illness in our training camps in the continental United States.

2. We had comparatively few battle casualties prior to the North African invasion and since then, fewer than had been contemplated.

From this time forward, however, we must be prepared to care for ever-increasing numbers of patients, both at home and abroad and returning from overseas.

Our quota of nurses for the fiscal year ending June 30, 1944, calls for over 51,000 nurses. To attain this objective we will have to procure 23,000 during the next ten months. Of this number, 95 per cent may be nurses who have had little or no postgraduate experience, provided they are basically well trained, but the other 5 per cent must be qualified to fill administrative, supervisory, and teaching positions.

On September 1, 1940, there were 976 nurses in the Corps, 208 of whom had had less than two years of service. One hundred thirty-one of this number were assigned to overseas service. There were fifty-four stations to which nurses were assigned, and there were few hospitals having more than 250 beds and only two having more than a thousand beds.

On September 1, 1943, in comparison, there were approximately 32,000 nurses assigned to more than 1,125 hospitals, ranging in size from 25 to over 3,000 beds. The Army is fortunate in having in the service at this time approximately 450 nurses well qualified to organize the nursing service of the hospitals under construction in the United States and for additional units for overseas service. Replacements will be required for the positions made vacant by such transfers, and it is estimated that 450 will be needed for these assignments and, in addition, we will need an extra 700 for supervisory and teaching positions for these hospitals.

The Hospital Division of the Army is planning to activate over 400 more hospital units before June, 1944, and this will necessitate more nurses well qualified to fill administrative, supervisory, and teaching positions.

Red Cross Volunteer Nurse's Aides have served in seventy-six Army hospitals since January of this year, and at present are serving in thirty-two. Five hospitals are conducting classes for additional aides, who will, on completion of their training, be available for assignment in those hospitals.—*Excerpts from a report presented by Colonel Florence A. Blanchfield, Army of the United States.*

American Red Cross Needs 791,000 Persons for Home Nursing

A program to enroll 791,000 persons in Red Cross Home Nursing classes during the coming year has been endorsed by leading Government experts at the annual fall meeting of the National Council on Red Cross Home Nursing.

This quota for 1943-44 is part of an ultimate national goal of 3,000,000. This is approximately 10 per cent of the women in the country between the ages of 15 and 59, who normally care for the sick at home, exclusive of those who already have had training as graduate nurses, Volunteer Nurse's Aides, and home-nursing students.

With 2,500 nurses needed each month for service in the armed forces, it is evident that no one can have the luxury of private-duty nurses.

In an annual report, Miss Olivia Peterson, in charge of Red Cross Home Nursing for the national organization, said that 533,483 persons completed the course in home nursing from July, 1942 to July, 1943, an increase of 137,269 over last year. Of this number, 80,592 were in school classes, the remainder in community classes of which 28.2 per cent were rural, and 71.8 per cent urban.

* For editorial comment, see pages 256-257.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (84)

Butte-Glenn County (1)

Caffaratti, Darius F., *Oroville*

Los Angeles County (52)

Aiken, William P., *Wilmington*
Ambler, A. Carleton, *Arcadia*
Bercovitz, Nathaniel, *Pasadena*
Bonynge, Thomas William, *Los Angeles*
Brodersen, H. N., *Los Angeles*
Cefalu, Victor, *Santa Monica*
Cleland, Robert S., *Los Angeles*
Crosby, Benjamin L., *Burbank*
Curtin, Edward D., *San Bernardino*
Duncan, Ray H., *South Gate*
Edelstein, Jacob A., *Los Angeles*
Edwards, Edward G., *Beverly Hills*
Fairchild, Nora M., *Los Angeles*
Falk, Rollin Merton, *Burbank*
Feder, Bernard H., *Los Angeles*
Finkelstein, Gertrude P., *Los Angeles*
Fischer, Peter N., *Sherman Oaks*
Fisher, Russell V., *Long Beach*
Gilbert, Alfred E., *Los Angeles*
Goldberg, Louis, *Los Angeles*
Gregory, Dewey Quintin, *Pasadena*
Grimm, John Elson, *Santa Monica*
Harrington, Kathleen R., *Los Angeles*
Hixson, A. H., *Hawthorne*
Horn, Paula Marie, *Los Angeles*
Janes, Dalziel O., *Long Beach*
Jorgensen, Gilbert Martin, *Los Angeles*
Joseph, Louis D., *Los Angeles*
Kahlstrom, Sylvia Shafer, *Long Beach*
Knox, John F., *Glendale*
Kugel, Arthur Irwin, *Los Angeles*
Lawrence, Lucy Katherine, *Montebello*
Manchester, Raymond D., *Camp White, Oregon*
Melinkoff, Eugene Borice, *Los Angeles*
Monaco, Louis, *Los Angeles*
Moss, Myer N., *Los Angeles*
Nethery, Winston G., *Los Angeles*
Phillips, Edward, *Los Angeles*
Prince, Charles Calvin, *Long Beach*
Prince, Dorothy Dunscomb, *Long Beach*
Robertson, Murl John, *Santa Monica*
Robinson, Emery Irvin, *Los Angeles*
Ryan, Clarence J., *San Pedro*
Sharpe, John Charles, *Los Angeles*
Sirmay, Elizabeth A., *Los Angeles*
Skinner, W. Clifford, *Van Nuys*
Szekely, Joseph L., *Los Angeles*
Tuta, Joseph A., *Long Beach*
Valensi, Albert, *Los Angeles*
Ward, Alsie Gray, *Huntington Park*
Wilkinson, Mary N., *Huntington Park*
Ziskoven, Hedwig Maria, *Los Angeles*

San Bernardino County (1)

Specht, Norman W., *Loma Linda*

San Diego County (3)

Macnamara, George A., *National City*
McBride, J. P., *San Diego*
Obrock, F. A., *San Diego*

San Francisco County (17)

Bonfilio, Marie DeCola, *San Francisco*
Dolman, Percival, *San Francisco*
Fesca, Helmut William, *San Francisco*
Gardner, Alfred E., *Ignacio*
Golman, Mervin Jack, *Fort Baker*
Greenberg, Jacob, *San Francisco*
Horn, Carl E., *San Francisco*
Hyde, Clarence E., *San Francisco*
Iseminger, Sidney Wells, *Sacramento*
King, Gordon Grant, *San Francisco*
Koch, Pearl Elizabeth, *San Francisco*
Marsh, Earle M., *San Francisco*
Moon, Henry D., *San Francisco*
Schmutz, Melvin A., *San Francisco*
Shenson, Ben, *San Francisco*
Silvani, Henry, *San Francisco*
Taylor, Charles E., *San Francisco*

Santa Barbara County (4)

Benning, Henry M., *Santa Barbara*
Carswell, John A., *Santa Barbara*
Jackson, Gustave B., *Santa Barbara*
Mulholland, Stanley C., *Santa Barbara*

Santa Clara County (1)

Giannini, Albert P., *Salinas*

Sonoma County (4)

Barnet, Garfield Stephen, *Santa Rosa*
Johnson, Paul A., *Santa Rosa*
Libby, John Elden, *Santa Rosa*
Miller, Arthur Campbell, *Santa Rosa*

Tulare County (1)

Malcolm, James C., *Visalia*

Transfers (2)

Elsbach, Kurt Joe, from San Francisco County to Los Angeles County.

Mollath, August, from San Diego County to Santa Barbara County.

Retired Members (2)

Chipman, Ernest D., *San Francisco*
Rothwell, William T., *Los Angeles*

† For roster of officers of component county medical societies, see page 4 in front advertising section.

In Memoriam

Baxter, Clarence Pennell. (Lieut. Col., U. S. A.) Died in Panama, April 27, 1943, while on active duty, age 52. Graduate of Tufts College Medical School, Boston, 1914. Licensed in California in 1923. Doctor Baxter was a member of the San Diego County Medical Association, the California Medical Association, and the American Medical Association.

✠

Chase, Albert Emery. Died at Santa Ana, September 15, 1943, age 63. Graduate of the Keokuk Medical College, College of Physicians and Surgeons, Iowa, 1907. Licensed in California in 1923. Doctor Chase was a member of the Orange County Medical Association, the California Medical Association, and the American Medical Association.

✠

French, John Rollin. Died at Los Angeles, September 28, 1943, age 63. Graduate of the University of Southern California School of Medicine, Los Angeles, 1906. Licensed in California in 1908. Doctor French was a retired

member of the Los Angeles County Medical Association and the California Medical Association.

✠

Green, Leonard Harry. Died at Los Angeles, September 26, 1943, age 46. Graduate of the University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore, 1922. Licensed in California in 1923. Doctor Green was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

✠

Hamlin, Oliver Deveta. Died at Oakland, October 11, 1943, age 73. Graduate of the Cooper Medical College, San Francisco, 1894. Licensed in California in 1895. Doctor Hamlin was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✠

Miller, Joseph Edward. Died at Los Angeles, September 13, 1943, age 54. Graduate of the Wisconsin College of Physicians and Surgeons, Milwaukee, 1912. Licensed in California in 1923. Doctor Miller was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✠

O'Flaherty, Aloysius E. Died at Santa Monica, October 7, 1943, age 72. Graduate of the Kansas City Medical College, Missouri, 1898. Licensed in California in 1922. Doctor O'Flaherty was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

✠

Pursell, Francis John. Died at Los Angeles, September 16, 1943, age 74. Graduate of the Long Island College of Medicine, Brooklyn, New York, 1899. Licensed in California in 1901. Doctor Pursell was a retired member of the Los Angeles County Medical Association, the California Medical Association, and an Affiliate Fellow of the American Medical Association.

✠

Quinn, William. Died at San Francisco, May 25, 1943, age 69. Graduate of the Cooper Medical College, San Francisco, 1905. Licensed in California in 1905. Doctor Quinn was a retired member of the San Francisco County Medical Society, the California Medical Association, and an Affiliate Fellow of the American Medical Association.

✠

Rakitin, Sergius S. Died at San Francisco, September 4, 1943, age 66. Graduate of the Military Medical Academy, Leningrad, R.S.F.S.R., 1909. Licensed in California in 1925. Doctor Rakitin was a member of the San Francisco County Medical Society, the California Medical Association, and the American Medical Association.

✠

Stafford, David Emmet. Died at San Francisco, September 25, 1943, age 65. Graduate of the University of California Medical School, Berkeley and San Francisco, 1903. Licensed in California in 1903. Doctor Stafford was a member of the San Francisco County Medical Society, the California Medical Association, and the American Medical Association.

✠

Thompson, Clarence Victor. Died at San Mateo, September 13, 1943, age 62. Graduate of the Cooper Medical College, San Francisco, 1903. Licensed in California in 1904. Doctor Thompson was a member of the San Mateo County Medical Society, the California Medical Association, and the American Medical Association.

Young, John Henry. Died at Lemon Grove, October 14, 1943, age 70. Graduate of the Ohio Medical University, Columbus, 1900. Licensed in California in 1900. Doctor Young was a member of the San Diego County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

Commercial (September, 1943)		50,100
Rural Health Program		5,000
War Housing Projects (approximate)		28,822
Marin	6,000	
Los Angeles	6,500	
San Diego	.....	
Vallejo	14,622	
San Francisco	1,700	
Total		83,922

Enrollment of families in the modified plan for War Housing Projects was begun on October 1. Sufficient interest is being shown by the tenants in practically all areas to suggest that an adequate enrollment will be secured to continue with prepaid medicine in these projects.

The commercial program is beginning to show continuous progress in increasing the numbers of new beneficiary members. Most of the recent additions have been made on the surgical contract.

The rural health program has now small units covering some nineteen counties, and is a starting nucleus for further development in these programs which are covering the great majority of the agricultural areas in the State.

* * *

Re: *Commercial Program*

Professional Members of
California Physicians' Service,
Addressed.

A recent survey of the California Physicians' Service professional members in Southern California shows that well over 80 per cent are convinced that California Physicians' Service holds the answer to prepaid medical care and are willing to support the program. A similar survey is being taken on a county basis in Northern California and, to date, returns indicate the same spirit of coöperation that exists in the South.

We realize that the shortage of physicians in California places a considerable amount of additional work on the doctors in private practice. Because of this fact, California Physicians' Service is offering only surgical coverage to new groups.

Financial operations for the commercial program during the month of July were as follows:

Membership dues	$60,400.15
Professional member registration fees	60.00
	60,460.15
Administrative costs	15,710,34
	44,749.81

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 5, bottom left-hand column.

Hospital and laboratory	4,927.62
Available for medical service	39,822.19
22,753.5 units of service at $1.75	39,818.63
Transferred to Unit Stabilization Fund	3.56
Previous balance of Fund	39,295.44
Present balance of Unit Stabilization Fund	$39,299.00

A. E. LARSEN, M. D.,
Executive Medical Director.

September 23, 1943.

ITEM XXXVII

Resolutions* Adopted at Conference of Representatives of Constituent State Medical Associations of Five Pacific States: Washington, Oregon, California, Idaho, and Arizona

Conference in Session in San Francisco, California, on Tuesday and Wednesday, November 2 and 3, 1943

The enactment by Congress of legislation providing funds to pay the cost of securing adequate maternity and pediatric attentions for the wives and children of enlisted men of the lowest four grades is an extension, as a war-time measure, of social security principles with which we, as practicing physicians, are in entire accord. It is our earnest desire to aid in every way possible the application of these services with fairness to the hospitals and to physicians who furnish the actual care, to the Congress of the people of the United States which provides the necessary funds, and especially to the wives and children who need and are entitled to receive these benefits.

We, therefore, representing the State Societies of Arizona, California, Idaho, Oregon, and Washington, in session in San Francisco, California, on Tuesday and Wednesday, November 2 and 3, 1943, propose the following resolutions as the expression of our deliberations.

Resolved, That this preliminary meeting serve as the basis for the formation of a permanent committee which shall be made up of the representatives of the Maternal and Child Welfare Committees of the respective states, chairmen preferred. This committee shall have one regular annual meeting, to be called approximately six weeks prior to the meeting of the House of Delegates of the American Medical Association, and to be called for special session at the request of representatives of any two states, for the purpose of discussion and solution of the various obstetrical and pediatric problems which may arise under this Act of Congress; and be it further

Resolved, That the Maternal and Child Welfare Committees in the various states be given authority to act in this matter by the governing boards of their respective State Medical Associations.

We, the representatives of the State Medical Societies of Arizona, California, Idaho, Oregon, and Washington, therefore propose to our respective societies the following resolutions:

WHEREAS, It is the intent of Congress that adequate maternity and pediatric services be made available to the wives and children of enlisted men of the four lowest grades; and

WHEREAS, The regulations now placed upon those directly concerned by this legislation put additional burdens upon coöperating hospitals and physicians, without any benefits to the patients; and

WHEREAS, The consummation of the intent of Congress is dependent upon the services of the rank and file of licensed practitioners and hospitals, who were not consulted in the planning of this program; and

WHEREAS, Under the present plan the usual and personal relationship between patient and physician is largely destroyed by the interposition of an agency with regulatory powers; and

WHEREAS, Physicians generally are willing and anxious that these women and children receive the best possible care; and

WHEREAS, There already exists in the Bureau of Allotments ample facilities for the disbursement to dependents of such funds as Congress may allocate therefore, we respectfully suggest that the proposed program can be more easily and economically administered directly through the Bureau of Allotments; and, therefore, we hereby suggest that the Bureau of Allotments shall, upon receipt of an affidavit signed by any individual licensed to sign birth and death certificates in the state in which he resides certifying that an enlisted man's wife is within two months of her estimated date of confinement, forward to the wife such monies as Congress may decide necessary to cover medical, hospital and nursing attentions during pregnancy and delivery; and be it further suggested that a similar method of furnishing an affidavit be adopted in disbursing funds to meet the costs of attention to the children of enlisted men of the grades specified; and be it

Resolved, That each state take definite action in conjunction with all other states in accord with these resolutions, to acquaint the congressional representatives of these states with the full intent of these resolutions; and be it further

Resolved, That copies of these resolutions be sent:

1. To the officers of the State Societies of the eleven (11) Western States; and

2. To the officers of the State Societies of such other states as may appear interested.

GORDON THOMPSON, M. D., Washington.
O. E. UTZINGER, M. D., Arizona
H. E. DEDMAN, M. D., Idaho
LESLIE KENT, M. D., Oregon
W. B. THOMPSON, M. D., California

Attest:
H. H. SKINNER, M. D., Washington,
Conference Chairman.
GEORGE H. KRESS,
Conference Secretary.

* Note.—These resolutions were not received in time for placement with other items. See pages 282-284. Also, page 254.

MEDICAL EPONYM

Felty's Syndrome

Augustus Roi Felty (b. 1895), when a junior member of the staff of the Johns Hopkins Hospital, was the author of a paper, "Chronic Arthritis in the Adult Associated with Splenomegaly and Leucopenia," in the *Bulletin of the Johns Hopkins Hospital* (35:16-20, 1924):

The syndrome occurred in individuals of middle age (45 to 65), the average being 50 years. All the patients gave a history of marked loss of weight since the onset of symptoms. . . . The arthritic process is distinctly chronic. . . . The objective findings, both by physical examination and roentgenographic study, are neither widespread nor indicative of a very damaging or destructive process. . . .

In every case the spleen was palpably enlarged . . . firm but not tender. . . . In every instance there was noted a yellowish-brown pigmentation of the skin. . . .

In all cases save one, there was a slight secondary anemia. . . . Most striking was the leukopenia, which was a distinctive feature in every case. The leukocyte counts varied from 1,000 to 4,200. . . .

The etiology is entirely obscure, though the various findings seem best accounted for as manifestations of a single disease process.—R. W. B., in *New England Journal of Medicine.*

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association. Meetings will convene in San Francisco. Date of the seventy-third annual session, to be held in 1944, to be announced later.

* * *

American Medical Association. Sessions will be held in Chicago (not St. Louis) on June 12-16, 1944. (See *The Journal of the American Medical Association,* November 6, 1943, page 644.)

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and the Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays.

KFAC presents the Saturday programs at 11:45 a. m., under the title, "Your Doctor and You."

In November, KFAC will present these broadcasts on the following Saturdays: November 6, 13, 20 and 27.

The Saturday broadcasts of KECA are given at 11:15 a. m., under the title, "The Road of Health."

Doctors at War":

Radio broadcasts of "Doctors at War" by the American Medical Association, in coöperation with the National Broadcasting Company and the Medical Department of the United States Army and the United States Navy, are on the air each Saturday at 2 p. m., Pacific War Time.

Pharmacological Items of Potential Interest to Clinicians*:

1. *Henry Schuman Hits the Bull's-Eye:* With Harvey Cushing's *Bio-bibliography of Andreas Vesalius,* prefaced by John Fulton, having 83 illustrations, costing $15; John Fulton's description of the *Harvey Cushing Collection of Books and Mss.,* at $8.50; G. Rosen's *History of Miner's Diseases,* prefaced by Henry Sigerist, costing $8.50; and Henry Sigerist's translation of *Arnold of Villanova's Treatise on Wine,* costing $10.

2. *More books:* Eliel Saarinen's *The City: Its Growth, Its Decay, Its Future* (Reinhold, New York, 1943) skillfully compares a city to the growth of any organism, which, if uncontrolled, gets cancerous and centrally necrotic. P. de Kruif's *Kaiser Wakes the Doctors* (Harcourt, Brace, New York, 1943) may be overenthusiastic, but it is interesting. Oxford announces Second Edition of John Fulton's *Physiology of the Nervous System* ($9). Sure to be good is E. V. Cowdry's *Microscopic Technique in Biology and Medicine,* and W. Truslow's *Body Poise* (Williams & Wilkins, Baltimore). Princeton Press offers C. E. A. Winslow's *Conquest of Epidemic Diseases: A Chapter in the History of Ideas.* The Office of Scientific Research and Development will send mimeo of R. A. Phillips, D. D. Van Slyke & Co.'s *Copper Sulfate Method of Measuring Specific Gravities of Whole Blood and Plasma.* Winthrop Chemical Co. will send bibliography on penicillin.

3. *Endocrines:* F. L. Dey (Endocrin., 33:75, 1943) notes that hypothalmic lesions prevent hypophyseal secretion of luteinizing hormone, resulting in genital hypertrophy. K. J. Karnaky *(Jour. Clin. Endocrin.,* 3:413, 1943) finds hexestrol less toxic but less potent than diethylstilbestrol, while J. G. Crotty & Co. *(Surg., Gyn., Obs.,* 77:130, 1943) think hexestrol is best for estrogenic therapy. More evidence supporting treatment of tumors by estrogens is given by W. M. Biden *(Brit. Med. Jour.,* 2:57, 1943) and G. H. Duncan, *(Ibid.* p. 137). K. N. Krishman finds that anterior pituitary extract (Antuitrin-G) promotes calcium retention *(Indian Jour. Med. Res.,* 30:589, 1942). H. E. MacDermott describes fine McGill mural on endocrines by Marian Scott,—like Homer Wheelon's *(Canad. Med. Assn. Jour.,* 47:224, 1943).

4. *Chemotherapy:* H. L. Chung and H. K. Chow *(Chinese Med. Jour.,* 61:71, 1942) find new sodium salt of mannite antimonic acid very effective in experimental kala-azar, but with some kidney and liver injury. The *Chinese Med. Jour.* now is published from Washington, D. C. A. I. Permer and A. I. Bernheim *(Gastroenterol.,* 1:765, 1943) note that ergotamine tartrate inhibits hemoconcentration and anatomical lesions in alimentary tract due to Shiga toxin. Q. B. Lee *(Texas State Jour. Med.,* 39:175, 1943) finds sulfanilamide locally significantly reduces mortality and morbidity in appendicitis. H. E. Carter and S. R. Dickman find anomalous amino nitrogen values in penicillin, suggesting caution; doubt presence of free primary amino group in penicillin *(Jour. Biol. Chem.,* 149:571, 1943). Another question,—does penicillin contain sulfur? Funny if it were to be relatively simple "enzyme" or "vitamin" competitor. F. Bernheim and H. I. Kohn *(Science,* 98:223, September 3, 1943) show propamidine (4:4 diamidinodiphenoxy propane) to be more powerful bacterial inhibitor

† In the front advertising section of *The Journal of the American Medical Association,* various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged.

* These items submitted by Chauncey D. Leake, formerly director of the University of California Pharmacologic Laboratory, now dean of the University of Texas Medical School, Galveston, Texas.

than stilbamidine and to act by inhibiting cellular oxidative metabolism.

5. *Etc.:* J. P. Muzzo *(Rev. Med. Exp.,* Lima, 2:25, 1943) finds overproduction of fibrinogen in anemias of interesting Carrion's disease (C. Howe, *Arch. Int. Med.,* 72:147, 1943; *Sci. Month.,* August, 1943). L. Pauling & Co. *(Science,* 98:263, September 17, 1943) confirm J. R. Marrack's framework of lattice theory of serological precipitation and agglutination *(Chemistry of Antigens and Antibodies,* Med. Res. Counc., London, Report No. 230, 1938). J. H. Quastel offers neat survey of enzymes and their mode of action *(Endeavor,* 2:85, 1943). A. Weil *(Growth,* 7:257, 1943) finds male rat brain matures chemically earlier than female—with aging there is increase of lecithins, galactolipids and sphyngomyelins at the expense of cephalin. W. Blackwood and H. Russell (*Edin. Med. Jour.,* 50:385, 1943) find prolonged nerve muscle injury in experimental immersion foot. Thorough study of toxicity of tannic acid by G. R. Cameron & Co. in *Lancet* (August 14, p. 179, and August 21, p. 218, 222, 1943).

New Chemicals Now Used on Wounds.—Radical revision in the treatment of wounds has taken place since the introduction of the new chemical therapeutic agents, the sulfonamids, peroxides, and chlorine-producing substances, according to Dr. T. Eric Reynolds, lecturer in pharmacology in the Medical School of the University of California, now on military leave. Especially is this true in regard to the lapsed-time factor; doctors can now safely undertake procedures on wounds much later than was formerly thought possible.

It seems probable that the mode of action of the sulfonamide group is to render the various body tissue fluids unfavorable as a medium for growth and multiplication of susceptible bacteria. After continued use, the chemical may also inhibit cellular growth, but this can be overcome by the application of several substances among which is cod liver oil.

The peroxides, especially the ones which give off oxygen slowly and continuously, are finding new and wide application in wound surgery. Both zinc and benzoyl peroxide can be used in combination with the sulfonamides.

The chlorine-delivering chemicals now used are a development of the tedious Dakin treatments employed in the last war. They offer a readily available means of keeping down wound infection by the liberation of chlorine.

San Francisco County Medical Society Telephone Service.—Nearly 2,500 persons, mostly newcomers to San Francisco, engaged physicians during the past three months through the San Francisco County Medical Society's "around-the-clock" telephone service bureau (WAlnut 6100).

Calls for assistance in engaging a physician received at County Society headquarters, 2180 Washington Street, during daytime hours totaled 455 in June, 440 in July, and 460 in August.

Night time calls for assistance were at approximately the same level in June and July, with 431 and 424 calls, respectively, but such calls fell off sharply in August, for some unexplained reason, with 227 night calls recorded during the month.

The Society established the telephone bureau last year as a public service especially for newcomers to the city and for oldtime residents whose doctors had departed for the war. The Society's membership was first polled to locate physicians who could take additional patients, and doctors who could take night calls.

California Tuberculosis Association: Christmas Seals.—With its customary double-barred cross in the lower lefthand corner, the 1943 Christmas Seal will arrive in homes throughout the country as the mail sale opens November 22.

Although the thought may not have occurred when the double-barred cross was selected as the emblem of the organized fight against tuberculosis more than forty years ago, its two arms joined together in a common cause have proved symbolical of the harmonious relationship between physicians and laymen in the battle aimed at the control of this disease.

The first sanatorium in America was founded by a physician who was later to become the first president of the National Tuberculosis Association. But even before the founding of this organization, members of the Southern California Medical Society were establishing a society to fight tuberculosis.

This new organization, started in 1902, grew to include laymen and, after several changes in name and constitution, finally emerged as the California Tuberculosis Association as it is known today. During the 30's, relationships between the Association and the physician in private practice were welded together to a point where every county medical society in California was lending its active support.

California Trudeau Society.—In 1940 it obtained a charter from the American Trudeau Society and, in a matter of months, became recognized as one of the leading organizations of its kind in the United States. Both through the Trudeau Society and the Association, numerous services have been made available to the private practitioner in California. The physician, meanwhile, has been contributing more than his part by his public and private endorsement of the Association and its work.

For the past two years CALIFORNIA AND WESTERN MEDICINE has published a section devoted to the papers presented at the annual meeting of the California Tuberculosis Association and the California Trudeau Society. The section later has been made available as a reprint.

Morris Herzstein Lectures at Stanford.—Dr. Oscar Ivanissevich, professor of surgery and director of the Surgical Institute at the University of Buenos Aires, will give the Morris Herzstein Medical Lectures for 1943 in San Francisco on November 15, 17, and 19.

Doctor Ivanissevich, who has an international reputation in plastic and reconstruction surgery, is exchange professor of surgery at the Stanford School of Medicine for the months of October and November.

The lectures will be given at 8 p. m. at the San Francisco County Medical Society, 2180 Washington Street. Titles will be:

November 15—*General Consideration of Echinococcosis.*
November 17—*Echinococcosis of the Liver.*
November 19—*Echinococcosis of the Lung.*

The Herzstein lectures were established in 1929 by the late Dr. Morris Herzstein of San Francisco, to be given under the direction of the medical schools of Stanford University and the University of California. They are given on alternate years by scientific men of outstanding achievement and are open to the public as well as to the medical profession.

Casualty Statistics of World Wars I and II.—A tremendously heartening report on one phase of war's grimmest subject, the casualties of combat, is contained in a current American magazine article by Rear Admiral Ross T. McIntire, Surgeon-General of the Navy and personal physician to President Roosevelt.

Reporting on the almost unbelievable success of modern methods of treating both battle wounds and disease, Admi-

ral McIntire reveals some new facts that should allay a good many of the fears of worried parents. For instance:

In the last war, 7 per cent of the men wounded in action died; this time, 2 per cent.

Last time, 20 per cent of all abdominal wounds proved fatal; this time, 5 per cent.

Last time, nearly half the compound fracture cases were permanently crippled and 12 per cent died; this time, not more than one per cent will die, only 10 per cent will be disabled, and there will be "very few" amputations.

In 1918, the Navy death rate for all diseases was 1179.66 per 100,000 men; today it is only 65.34 per 100,000.

Of 4,039 casualties (Army, Navy, and Marine) treated on one hospital ship in the south Pacific, only seven men have died.

All this, says the Admiral, is "unprecedented in the history of warfare."

"The record," he points out, "is one that gives a sense of security to any fighting man, and one that gives hope to civilians after the war, particularly those injured in industrial and motor-car accidents."

Credit for the drastic reduction in deaths, both from wounds and diseases, is awarded by Admiral McIntire to three main innovations of this war, in addition to the general improvement in medical techniques. These are blood plasma, two new drugs (the sulfa group and penicillin), and speed.

Isolation Unit Sought for Los Angeles County Hospital.—Prompt action in setting up facilities for proper isolation of smallpox cases was recently urged upon the Los Angeles Board of Supervisors by County Superintendent of Charities Arthur J. Will.

Since the discontinuance of the Los Angeles Isolation Hospital, also known as the pest house, in 1938, Will said there "has been no provision made either in the city or the county to meet the eventuality of a smallpox epidemic."

"Should it become necessary to admit even one smallpox patient to the communicable disease unit of the General Hospital, it would be necessary to vaccinate all patients and personnel," he said.

"Such a program of vaccination would not absolutely guarantee against the spread of the disease which might be carried to other units of the hospital."

Will said that when an epidemic occurs, it would be impossible to admit such patients without serious consequences to other patients and to the employees of the institution.

American Board of Obstetrics and Gynecology.—The next written examination and review of case histories (Part I) for candidates will be held in various cities of the United States and Canada and by special arrangements at Army and Navy stations on Saturday, February 12, 1944, at 2 p. m. Candidates who successfully complete the Part I examination proceed automatically to the Part II examination held later in the year. All applications for this year's examinations must be in the office of the secretary by November 15, 1943.

The office of the Surgeon-General (U. S. Army) has issued instructions that men in service, eligible for Board examinations, be encouraged to apply and that they may be ordered to detached duty for the purpose of taking these examinations whenever possible. The office of Surgeon-General of the U. S. Navy presumably takes a similar attitude on this matter.

The place of the Board's Part II examination in May or June, 1944, has not yet been decided, but it is likely to be held in that city nearest to the largest group of candidates. The exact time and place will be announced later.

If a candidate in Service finds it impossible to proceed with the examinations of the Board so that his plans are thus interrupted, deferment of parts of these without time penalty will be granted under a waiver of our published regulations covering civilian candidates.

For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh, 6, Pennsylvania.

Medical Information Concerning the War Effort.—The Johnson & Johnson Research Foundation, New Brunswick, New Jersey, through Dr. Ross G. Harrison, chairman of the National Research Council, has announced the acceptance by the National Academy of Science—National Research Council—of a grant from the Johnson & Johnson Research Foundation in the amount of $75,000. The grant was made to enable the Division of Medical Sciences of the Council, under the chairmanship of Dr. Lewis H. Weed, to gather medical information pertaining to the war effort and to disseminate summaries. The program of the Division of Medical Sciences of the National Research Council contemplates coverage of the various medical reports and bulletins which emanate from civilian and military activities throughout the world. The enterprise should fill a much-needed gap in the war effort in medicine; for one of the greatest difficulties encountered in medicine today lies in providing adequate up-to-date information to the medical officers of the armed services, both in this country and abroad, and in making the experience of war medicine available as far as possible to civilian physicians.

The Johnson & Johnson Research Foundation appropriation to the National Research Council becomes immediately available; in accordance with present plans, it will be utilized in the period up to June 30, 1945. A central office will be established in Washington, and reporters will be appointed in various foreign countries so that a staff of special observers abroad will be working under the direction of the central office. The various theaters of operation present medical problems in which climate, season of year, distribution of insects, distribution of disease, all play different rôles. Reports from widely separated parts of the world will be of the greatest medical importance, and it is hoped that, with the combined effort, much of significance will be achieved.

The Johnson & Johnson Research Foundation was established on January 1, 1940, as a nonprofit philanthropic organization by Johnson & Johnson, New Brunswick, New Jersey, with the express purpose of supporting research and development of products to serve the medical profession. It has made appropriations for both fundamental and developmental investigations and is currently sponsoring about one hundred projects located in twenty-eight universities. The fields of medical interest which have largely been supported are pharmacology (including antiseptics), allergy, physiological studies in pediatrics and human fertility.

Hormones and Cancer: Undergraduate Contest.—The third nation-wide competition for the Schering Award is now open. Three major prizes of a total value of $1,000 will be awarded to undergraduate medical students who submit the best critical dissertations on the subject, "Hormones and Cancer." As in previous years, the judges for the Schering Award will include outstanding American investigators in the fields of endocrinology, medicine, and chemistry. For information, communications should be addressed to "The Interne," 7 East Forty-Second Street, New York, 17, N. Y.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Dr. Frank W. Otto Is Named to State Medical Board

Governor Earl Warren today appointed Dr. Frank W. Otto of Los Angeles as a member of the State Board of Medical Examiners, succeeding Dr. Charles B. Pinkham of San Francisco, resigned after thirty years of state service, most of it as secretary-treasurer of the board.

Governor Warren revealed he has had Doctor Pinkham's resignation since February. Doctor Pinkham, withdrawing from the board at the compulsory retirement age of 70 years for salaried officials, said he feels the need of a rest after three decades of work as the executive member of the medical profession's regulatory agency.

Doctor Pinkham Lauded

The governor sent Doctor Pinkham a letter expressing "the gratitude of the people of our state for your long, honorable and distinguished service."

Doctor Otto will serve out Doctor Pinkham's unexpired term, ending January 15, 1944.

State officials announced Dr. Frederick N. Scatena of Sacramento has been acting as secretary-treasurer of the board.

Doctor Otto, 50, was graduated from the University of Southern California Medical School in 1921. He is the senior attending physician of the Los Angeles County General Hospital, a fellow of the American College of Physicians, assistant clinical professor of medicine at the University of Southern California, past president of the university's alumni association and a member of the council of the Los Angeles Medical Association.—*Sacramento Bee*, October 6.

Governor Warren Appoints Dr. Albert S. Chapman to State Medical Board

Sacramento, Oct. 19 (U.P.).—Governor Earl Warren today announced appointment of Dr. Herbert S. Chapman of Stockton to membership on the State Board of Medical Examiners. He replaces Dr. Frederick De Lappe of Modesto, whose term expired.—Los Angeles *Daily News*.

Industrial Medicine Start Credited to Long Beach Physician

Dr. Andrew M. Harvey, assistant city health officer of Long Beach, was described as "the father of industrial medicine in America" in the leading article of the current issue of *Industrial Medicine*. The 125-page magazine is the organ of the American Association of Industrial Physicians and Surgeons.

The Long Beach official is declared to have been "the first medical director of this country," having been appointed to that position by the Crane Company of Chicago in 1896.

Doctor Harvey left his post in 1937 and came to Long Beach to retire. Here he was recalled to active service a year ago by the need of the city health department for a competent executive trained in public health.

First steps to equip industrial workers with protective glasses was taken by Doctor Harvey, who himself was the founder of the American Association of Industrial Physicians and Surgeons, on whose board of directors he served for many years.

Under his leadership and that of his colleagues, Doctor Harvey recalls the successful campaigns waged for factory safety, the elimination of silicosis as an industrial disease and the introduction in factories of salt tablets for workers, to replace salt lost in perspiration.

Rest periods for women, lunch rooms and shower baths were pioneered by Doctor Harvey and others in the association.

Although little progress in controlling the common cold was made, its spread was prevented by insisting that workers afflicted remain off the job so that others would not be contaminated.

For his work in industrial medicine Doctor Harvey was awarded a degree of doctor of science by Knox University at Galesburg, Illinois.—Long Beach *Telegram*, October 6.

Surgeon-General of U. S. Army Visits Palm Springs

Palm Springs entertained distinguished visitors Tuesday when Major-General Norman T. Kirk, surgean-general of the Army, visited Torney General Hospital in the afternoon and was guest of honor at a reception that evening at the Officers' Club. General Kirk is at present on a tour of Southern California medical installations.

Accompanied by Colonel Raymond W. Bliss of the surgeon-general's office, General Kirk arrived at Torney Tuesday afternoon at 2:30, where he was greeted by Colonel A. B. Jones, commanding officer of the local institution, and official party. An inspection of Torney followed.

Tuesday night General Kirk and Colonel Bliss were honored at a reception at the Officers' Club. Officers of Torney General Hospital and their wives and officers of the Twenty-second General Hospital and their wives greeted the distinguished visitors.

Colonel Bliss, who is chief of operations and training of the surgeon-general's office, received notification when in Banning, where the party went after leaving here, that he had been promoted to brigadier-general.

Colonel William B. Shambora, surgeon for the Army ground forces, and Lieutenant-Colonel Harold A. Furlong, surgeon for the Desert Training Center communications zone, accompanied General Kirk on his tour of medical installations.

Interesting Career

General Kirk has had a varied and interesting career in the Army. His first service was at the Soldiers' Home in Washington, D. C., in 1912. Since then he has been assigned to many Army hospitals, including the Walter Reed General Hospital, Washington, D. C. He has completed tours of duty at Johns Hopkins University Hospital in Baltimore and other prominent civilian hospitals. In recognition of General Kirk's service, on May 28, 1943, the Senate of the United States confirmed the President's nomination of him as the surgeon-general of the United States Army.

Noted Authority

General Kirk is recognized as a general surgeon of extremely high capacity, being particularly well known for his work on bone and joint surgery. His volume on "Amputations: operative technique," which appeared in 1924 and which was the result of large experience following World War I, is still a standard textbook. In addition to this book he has written a great many other articles on clinical and operative surgery. General Kirk has been honored by membership in the most selective surgical societies of the United States.—Palm Springs *Desert Sun*, October 8.

Palo Alto Doctor Cited for Service on Guadalcanal

A Palo Alto physician has been awarded the Legion of Merit for exceptionally meritorious service on Guadalcanal, it was announced yesterday by Twelfth Naval District headquarters.

The medical hero is Lieutenant Ferrall H. Moore, 252 Seale Avenue, who, according to his citation, attached to a Marine aircraft wing and was in charge of the evacuation of casualties at Henderson Field, Guadalcanal, from November 30, 1942, to February 4, 1943.

"With outstanding ability Lieutenant Moore reorganized the plan which facilitated the loading and evacuation of patients at the air field," the citation read.—San Francisco *Chronicle*, October 28.

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.
San Francisco

Malpractice: Sufficiency of Evidence to Sustain Verdict Against Physician

A California physician and surgeon was named as defendant in a malpractice action to recover damages for alleged disfigurement and permanent deformity resulting from operations performed on the patient's nose. Judgment was rendered for the plaintiff against the defendant physician in the sum of $5,000, and on appeal from this judgment in the action, entitled *Soest* vs. *Balsinger*, 60 A. C. A. 519, the District Court was presented with the question of whether evidence introduced in the trial court was sufficient to sustain the verdict.

The Court ruled on September 13, 1943, that, in a malpractice case, it is not necessary for the plaintiff to demonstrate conclusively and beyond possibility of a doubt that the defendant physician's negligence resulted in the injury to the patient and, further, that the causal connection between the physician's alleged negligent acts or omissions and the alleged damage need not be established with such

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions, and analyses of legal points and procedures of interest to the profession.

certainty that any other conclusion is excluded. The judgment in favor of the patient and against the physician was affirmed.

In May of 1940, on advice of two physicians that she needed a submucous resection of the nose in order to relieve severe headaches and difficult breathing, the plaintiff consulted defendant. After examination, defendant operated upon the plaintiff's nose, first applying a local anesthetic, and performed a submucous resection. In addition, he removed a hump on plaintiff's nose and a scar on her forehead. The nose was packed with gauze and, after a week of daily visits to the defendant's office, the packing was removed and infection was discovered.

To relieve the condition resulting from infection, defendant incised both nostrils. In August, defendant performed a second operation on the patient's nose, which was then completely closed because of the infection. Three holes developed in the patient's septum, and in October the plaintiff complained to defendant of these holes, the misshapen rims of the nostrils and other ill-effects of the operations. In November the defendant physician urged plaintiff to submit to a further operation, but she refused owing to her lack of confidence in him. Plaintiff thereupon commenced this action, charging defendant with negligence in the performance of the operation and in her subsequent care. It appeared at the trial that plaintiff's nose was scarred and that there were holes in her septum.

The evidence submitted by plaintiff to support her charge of negligence consisted of testimony of the nurse who assisted at the first operation, to the effect that after the packing was removed the defendant had charged this nurse with a "slip-up" in technique and had blamed her for not sterilizing instruments properly. In addition, plaintiff produced three physicians and surgeons who gave their expert opinions, the first testifying that no surgery should be performed where infection is present (the defendant here had performed a second operation after the discovery of the infection). A second physician testified that he had found three holes in the septum of the plaintiff's nose, and that an attempt had been made to perform a submucous resection to remove a portion of the septum and that the resultant holes in the nose would affect plaintiff's health. He further testified that certain depressions and indentations on plaintiff's nostrils could have been caused by taking away too much tissue in the performance of the operation, and that the correction of the nose would be an extremely difficult thing. The third physician presented by plaintiff testified that perforations in the septum following the submucous resection may be caused "either from perforation of both of layers through and through, perforations at the time of surgery which broke down the circulation and caused the perforation. They may be due to infection either before or after surgery."

On appeal the defendant physician contended that the plaintiff had failed to support her charge of malpractice by sufficient evidence, and cited authorities to the effect that negligence on the part of a physician or surgeon will not be presumed and that it must be affirmatively proved. In the absence of expert evidence it will be presumed that a physician or surgeon exercised the ordinary skill and care required of him in treating his patient.

The Court ruled that the evidence above summarized was ample to support a finding by the jury that the physician did not use that degree of care and skill exercised by physicians in the same locality. Particular emphasis was placed upon the fact that a second operation had been performed after discovery of the infection. Authorities were cited to the effect that the danger of infection from such a field of operation is a matter of common knowledge and that a jury is authorized to draw the reasonable inference of negligence.

LETTERS†

Concerning Botulism Antitoxin: Where Obtainable:

STATE OF CALIFORNIA
DEPARTMENT OF PUBLIC HEALTH

October 6, 1943

To the Editor:

We would appreciate your giving publicity to the enclosed in CALIFORNIA AND WESTERN MEDICINE.

We desire the medical profession to be informed where botulism antitoxin can be obtained.

Very truly yours,

(Signed) MILTON P. DUFFY, *Chief,*
Bureau Cannery Inspection.

* * *

BOTULISM

Keep This for Ready Reference

Cases or suspected cases should be reported at once to the *State Department of Public Health.* All foods suspected of being the source should be held for laboratory examination. Keep opened foods under refrigeration.

Antitoxin for Treatment

Antitoxin for treatment is available and should be administered as soon as botulism is suspected. Antitoxin may be obtained *day* or *night* from the *Lederle Laboratories, Inc.*

Phone direct to: San Francisco—274 Brannan Street, EXbrook 3730, or DOuglas 6500; Los Angeles—643 South Olive Street, TUcker 1127.

To be effective, antitoxin must be administered as soon as possible. Use any facilities you can enlist for rapid transportation.

A case of moderate severity may require several ampules, severe cases more. In instances where the costs cannot be met by the individual or the local department, the *Health Officer* is authorized to provide the antitoxin at the expense of the State Department of Public Health. The State Department of Public Health should be notified at once of any such commitment.

Treatment

Antitoxin, one ampule (10,000 units), should be injected intravenously as soon as possible and repeated every four hours until the toxic condition is alleviated. There is considerable evidence the antitoxin is more effective if combined with 5 per cent glucose solution. Intravenous 5 per cent glucose solution may be started before antitoxin is available. General treatment should include rest in bed, avoidance of fatigue, exclusion of visitors, complete evacuation of the lower intestinal tract unless such procedure is too fatiguing, forcing of fluids. Tube feeding may be required. Suction for removal of salivary secretions frequently is necessary. Keep your *Drinker* respirator in mind. Its use is indicated whenever respiratory depression sets in and when respiratory stimulants and oxygen are ineffective.

Prophylaxis

For those who have eaten the suspected food but have not developed symptoms, 1,000 to 2,500 units intramuscularly. If symptoms develop, treat with full therapeutic doses intravenously.

Caution

This antitoxin is made from horse serum. Test for sensitivity.

—California State Department of Public Health.

†CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

Concerning Medical Literature Sent to Military Camps —A Letter of Appreciation:

(COPY)

HEADQUARTERS
OFFICE OF THE SURGEON, STATION DISPENSARY
FORT MASON, CALIFORNIA

October 13, 1943

Dear Doctor Kress:

The copies of the *Journal of American Medical Association and Surgery, Gynecology and Obstetrics* arrived today and, on behalf of the staff stationed here at the Station Dispensary, please accept my sincere thanks for your kindness. The journals will be well utilized and will prove of distinct value at this office.

Again, our thanks.

Very cordially yours,

(Signed) JEAN S. FELTON,
Major, Medical Corps, Surgeon.

Concerning a Legal Opinion on Admission of Patients to County Hospital:

(COPY)

Re: Admission of patients to county hospitals.

L. A. Alesen, M. D.
1401 South Hope Street
Los Angeles, California

Dear Doctor:

Please excuse our delay in sending you an opinion with regard to admission of patients to county hospitals.

We will endeavor to set forth in this letter the California law with regard to this question.

The law covering admission of patients to county hospitals is set forth in *Goodall* vs. *Brite,* 11 Cal. App. (2d) 540, where it was held that county hospitals may admit indigents as patients and may admit so-called "part-pay patients," but may not admit persons financially able to pay the costs of private hospitalization and medical care.

The so-called "part pay" group was defined by the Court to include persons able to pay some portion of the costs of hospitalization and medical care but unable to pay the full cost thereof.

With respect to persons able to pay hospitalization and medical costs, the Court held as follows:

"We, therefore, conclude that the admission and treatment of patients in the county hospital who, either themselves or through legally responsible relatives, can provide themselves with equally efficient care and treatment in private institutions, does not promote the health and general welfare of the citizens of Kern County and is not a proper exercise of the police power of that county and results in the use of public money for private purposes."

The case of *Goodall* vs. *Brite* is the only California decision upon the subject of admission of patients to county hospitals and is determinative of the present California law.

The Court's ruling, however, against the admission of patients to the Kern County Hospital who were financially able to provide equally efficient care and treatment in private hospitals was based, in part, upon the fact that there were adequate private hospital facilities in Kern County. Further, the Court stated that another class of patients which should be admitted to county hospitals were the victims of public disaster, accident, or sudden illness. This type of patient, the Court said, should be admitted promptly and if subsequent investigation disclosed ability to pay for hospitalization the county authorities could then require them to pay in full the cost of care and treatment received.

In view of these statements in the opinion in *Goodall* vs. *Brite,* it is our opinion that, if exigencies created by war conditions rendered private hospital facilities in the county inadequate, so that even persons with ample means were unable to obtain admission to private hospitals or proper care therein, it would be proper to admit them to county hospitals, charging a proper fee. If the county hospital is the only institution where hospitalization can be obtained, then it would promote the general welfare of the county to deviate from the rules set down in the case of *Goodall* vs. *Brite.*

If you have any further questions, please let me know.

Very truly yours,

HARTLEY F. PEART.

P. S.: This opinion is concerned solely with questions of indigency and we have not considered other classes of patients who are entitled to admission to county hospitals, such as criminals, insane persons, or those suffering from contagious diseases. H. F. P.

Concerning Assignment of Hospital Nurses:

(COPY)

ATTENDING MEDICAL STAFF
THE CALIFORNIA HOSPITAL
1414 South Hope Street
Los Angeles

To the Members of the Attending Medical Staff:

The undersigned committee was appointed by the Executive Medical Board to coöperate with federal and state agencies in assisting in the program of providing adequate nursing service in military and civilian service. The Committee has made a study of this problem because of the acute shortage of nurses in our hospital and an analysis of cases in the hospital, and finds the following situation:

First: This hospital, as well as all other hospitals, must coöperate in utilizing the graduate nurses for the most essential nursing services in caring for the ill and injured. Attendants must be trained and used as auxiliary workers taking care of many duties formerly performed by nurses that can and should be performed by attendants.

Second: An investigation has revealed that the medical staff in this hospital is using about as many special duty nurses at the present time as prior to the war emergency. We find that many of these nurses are assigned because of the request of the patient purely from an economic standpoint.

The Committee, therefore, in coöperation with federal and state authorities, seeking to eliminate as much as possible of luxury nursing, requests physicians on the staff of the hospital to only assign special nurses on the basis of medical need. Every morning the Committee will have available from the Director of Nurses' Office a report indicating the special nurse assignments in the hospital, and depending upon the condition of the patient, will give a memorandum to the doctor at various periods requesting him to check the need for continuing the assignment of special nurses.

We, therefore, solicit your consideration of the problem and request your coöperation in trying to assist in the war effort by making more nurses available for essential military and civilian needs.

Very truly yours,

THE COMMITTEE OF THE EXECUTIVE MEDICAL BOARD:

E. J. Cook, M. D., *Chairman.*
George F. Schenck, M. D.
Walter A. Bayley, M. D.
H. D. Van Fleet, M. D.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVI, No. 11, November, 1918

EXCERPTS FROM EDITORIAL NOTES

Influenza.—Epidemic influenza has reached the Pacific Coast in its pandemic progress from eastern Europe around the world. It is doubtless the same disease which appeared in pandemic form in 1889-1890, and, previous to that, at more or less regular periods for many centuries. Its specific cause is unknown, although the name "influenza bacillus" was attached by Pfeiffer in 1892 to a certain organism found in the nasal and bronchial secretions. This bacillus is found in only a minority of cases in the present epidemic. . . .

Epidemic influenza, to use the Italian term, or la grippe, after the French, is characterized now as previously, by the extraordinary speed of its spread, this being, however, no more rapid than means of human conveyance, and by the high percentage of the population attacked. . . . Previous epidemics have attacked as high as 40 per cent of the population. Thus far, from 10 to 15 per cent of the cases have been complicated with pneumonia, to which most of the fatalities are due. Approximately one-third of the pneumonias prove fatal, although there is reason for believing that this mortality will be lower in California. . . .

The Psychopathic Hospital Idea.—One of the institutions badly needed by California, and especially by the community in and about San Francisco, is a Psychopathic Hospital, and the medical profession as a whole should interest itself in the effort now being made to obtain such. . . .

However, the time has long since passed when it is necessary to enumerate arguments in favor of a Psychopathic Hospital. That one is an absolute necessity, is a truism. At present the only argumeent against its immediate erection is the expense. Surely, a rich, self-conscious State like California will not lag behind and allow this need to continue unmet. The thousands of dollars now spent by courts, social agencies, schools, charitable organizations and hospitals in trying to solve these problems of the psychopathic individuals would more than build and maintain a Psychopathic Hospital.

Newspapers and the Doctor.—How the average newspaper does enjoy poking fun at the doctor! And how often it slurs him and his work, and, by innuendo and unrefuted misstatement, allows him to suffer injustice! Such, doubtless, is to be expected, and as a general thing arouses only amusement at the expense of the newspaper. . . .

The Communal Kitchen.—Pressure of food conditions due to the war has led to widespread employment of communal kitchens in European countries. England has this year established national kitchens, under the Director of the Communal Kitchens Section of the Ministry of Food. Late in March [1918] there were in that country 250 kitchens with the probability that inside of two months the number would increase to 1,000. . . .

Flight Surgeons.—For the care and conditioning of fliers in the air service, the Government is now [1918] appointing

(Continued in Front Advertising Section, on Page 22)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. Scatena, M. D.,
Secretary-Treasurer

Board Proceedings

At the meeting of the Board of Medical Examiners held at 1020 N Street, Sacramento, October 18 to 21, 1943, fifty-two candidates presented themselves for written examination, fifty of whom were physicians and surgeons, one drugless practitioner, and one midwife.

This being the annual meeting of the Board, election of officers was held. The new officers are as follows: Dr. George Thomason of Los Angeles, President; Dr. Alvin E. Cerf of San Francisco, Vice-President; Dr. Frederick N. Scatena of Sacramento, Secretary-Treasurer.

There will be an additional written examination held at Native Sons Hall, San Francisco, November 16 to 18, 1943, as well as an oral examination, which will be held at the Board office, 515 Van Ness Avenue, San Francisco.

Upon petitions for restoration of certificate, the Board acted favorably in the following instances:

Howard Doane Mayers, M. D., on October 19 was placed on probation for a period of five years with specified terms.

Alfred Edward Meyers, M. D., on October 19 was placed on probation for a period of five years with specified terms.

Milton Francis Novotny, M. D., on October 19 was placed on probation for a period of five years with specified terms.

David Andrew Stevens, M. D., on October 19 was placed on probation for a period of five years.

News

"Governor Earl Warren today appointed Dr. Frank W. Otto of Los Angeles as a member of the State Board of Medical Examiners, succeeding Dr. Charles B. Pinkham of San Francisco, resigned after thirty years of State service, most of it as secretary-treasurer of the Board. Governor Warren revealed he has had Dr. Pinkham's resignation since February. Dr. Pinkham, withdrawing from the Board at the compulsory retirement age of 70 years for salaried officials, said he feels the need of a rest after three decades of work as the executive member of the medical profession's regulatory agency. The Governor sent Dr. Pinkham a letter expressing 'the gratitude of the people of our State for your long, honorable and distinguished service.' . . . Dr. Otto, 50, was graduated from the University of Southern California Medical School in 1921. He is the senior attending physician of the Los Angeles County General Hospital, a Fellow of the American College of Physicians, Assistant Clinical Professor of Medicine at the University of Southern California, past president of the university's alumni association, and a member of the Council of the Los Angeles Medical Association. . . ." (Sacramento *Bee*, October 6, 1943.)

"Dr. Ralph C. Lewis, son of Mr. and Mrs. Harry W. Lewis of Santa Ana, medical missionary to China, is expected to be among the exchange prisoners aboard the *Gripsholm* when it returns from its mission of taking 1,300 Japanese nationals back to their homeland, it is disclosed here. . . . Actual exchange of the prisoners, according to word from the State Department to Dr. Lewis' parents, will

(Continued in Back Advertising Section, on Page 34)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.